# DYING PEACEABLY

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# PREFACE

***Introduction***

Elizabeth Kűbler-Ross (1975) describes death as that which gives life meaning. Death limits the time we have on earth to learn, love and experience all that life has to offer. It is death that reminds us life is precious and temporary. Most people do not consciously think of death or dying unless faced with a reminder of death, such as the death of a friend or loved one, the discovery of a potentially life-threatening illness, or news of the latest terrorist attack. Death gets noticed when it affects us, and sooner or later it affects us all.

***Organization***

This project is divided into three sections 1) literature review, 2), annotated bibliography and 3) the appendix (*Dying Peaceably*). The annotated bibliography and the literature review were an intellectual journey of sorts in search for some insights into death and dying. The appendix is a self-help booklet for the terminally ill.

***Annotated Bibliography and Literature Review***

The annotated bibliography is exclusively comprised of empirical studies and research material. The literature review includes other types of reference material such as

books and reference manuals. Most annotated bibliographies and literature reviews are typically comprehensive and focus on one subject. This annotated bibliography and literature review explored a sampling of three themes 1) religion, 2) fear of death and meanings of death, and 3) near-death experiences.

Religion was chosen for potential insights into people's attitudes toward death and dying with regard to religion. Does one's religion play a part in one's fear of death? Fear of death and meanings of death were chosen to give insights into what people are afraid of and what death means to them. Near-death experiences were chosen because these were the experiences of people who seemingly died and were revived. Are there possible insights to be derived from these people's accounts?

***Appendix***

The appendix, *Dying Peaceably*, is a self-help booklet written for the terminally ill. The idea for *Dying Peaceably* grew out of personal experiences. From August 1996 to June 1998, I lost five immediate family members father (August 1996), sister (January 1997), husband (June 1997), grandmother (January 1998), and mother (June 1998). With each death, I questioned my own mortality. I wondered if they died peaceably. Each death contributed to the

desire to write a thesis such as this one. But, in retrospect, it was my father's death that was the definitive factor. He was the only one of the five who was terminally ill. The others passed away more or less suddenly and unexpectedly.

My father had time to prepare for his transition from life to death. In June of 1996, my father called and told me he had melanoma cancer. The doctor gave him a maximum of 6 months to live; he lasted 3 months. I did not know what to say or do to help him, so I did nothing. If, at the time, I had access to the information of this thesis I could have taken a more proactive position with my father. I would have shared the information with him. I would have felt as if I made a difference.

The appendix is written to provide help for the terminally ill in overcoming fear of death and gaining acceptance of death. The appendix is not meant to cover every possible obstacle the terminally ill will face, but rather includes the most common obstacles experienced by the terminally ill. The appendix is in no way suggesting the terminally ill will experience any or all of the obstacles described. It is designed to describe the more common obstacles and give suggestions for overcoming them.

# LITERATURE REVIEW

The primary purpose of this literature review is to find insights into the following aspects of death and dying: religion, fear of death and meanings of death, and near-death experiences. More specifically, how does religion affect fear of death? What do we fear about death? What can we learn from near-death experiences?

Kastenbaum (1996) conducted a unique study showing that once people reflect on death, they realize death has functionality for both society and the individual. If there were no death, society would change considerably. Without death, the world could become overcrowded. Society may be forced to increase or make more stringent birth control policies. There may be new rules or understood norms for the governance of human relationships; marriage may not be thought of as a lifetime commitment. Certain economic systems may face problems or potential fail. Mortuaries, cemeteries, life insurance companies, etc., may be forced out of business or find ways to adapt to a world without death. Would religions suffer? It would seem many Christian-based religions would have less to offer in the way of reward and punishment with regards to heaven and hell.

If there were no death, it could affect the individual in many ways. If there were no time limit on living, perhaps people would lack of ambition. After all, there is always time to complete a project or achieve a goal. Why get in a hurry to do things? Would a deathless society cause a general lessening of an individual's responsible attitude? Would people live their lives recklessly? One can see that death has great potential for functionality; and since there is no escaping death, perhaps our best response to death is to learn as much as we can about the subject.

***Religion***

This section of the literature review looks at how religion relates to fear of death. Does religion soothe, calm, or in some way help take the edge off the fear of death? Is it possible for someone with a high level of fear of death to be comforted enough by his or her religion to lessen the fear of death? Osarchuk and Tatz (1973) wrote "a value system regarding religion… may in many individuals serve one of the functions for which it is intended, that of helping to keep the unpleasant affect to a minimum" (p. 260). The value system of the religion referred to in the quote would seem to be one of offering

reward and punishment for life's deeds. It seems reasonable to infer from the quote that Osarchuk & Tatz are referring to those individuals who believe they have acted according to their religion's rules. Since they have acted accordingly, their religion offers some sort of promise of a desirable reward or afterlife, and therefore is capable of taking the edge off of the fear of death.

Is it reasonable to expect a non-religious person to turn to religion in response to his/her fear of death? Most religions have a set of rules or protocols regarding death. With a set of rules to follow regarding death, do some people feel a sense of control, predictability, or power over death? In the face of death, do people turn to religion for comfort and solace? McGrath (2003) posits the majority of terminally ill people do not turn to religion in response to their illness. They do not experience a conversion of sorts. The few who intensify their religion do not turn to new concepts or ideas, but rather strengthened the beliefs they already have.

If one thinks about all of the different religions, each with its own set of protocols regarding death, how would one choose a specific religion under the pressure of death threat? If one were faced with a terminal illness and time seems to be a factor, how could one make such a

complex decision in a timely manner? Choosing a religion can be a very complex process. Which religion has the right answers to the questions regarding death and/or the plethora of other issues one may turn to religion to answer?

Which religion's protocols and rules of conduct are right? How would one determine which religion has the right rules? Would it matter if the rules are right: or is it simply enough to have rules? Any rules, as long as they serve as some sort of guideline for death: a guideline offering some sort of predictability and sense of control to an otherwise unknown, and thereby possibly soothing or lessening the fear of death.

It would seem to choose a religion intelligently one would have to know something of the many choices and what each choice would have to offer and stand for. There are so many religions; becoming even remotely knowledgeable of each religion could become quite time consuming. It would seem that people who seek a religion do so in some fashion that reaffirms their personal core beliefs or base values. One would expect the closer the match between the religion and the person's core beliefs the more satisfaction the union would offer. In such a short time constraint, how

does one find a religion that suits or matches one's personal beliefs?

For many it takes a lifetime to understand and personalize the rules of their religion. It takes time to come to terms with why the rules exist and how the rules apply to the individual person. The rules must have personal meaning or why would one simply blindly follow rules that have no meaning or do not make sense. If one takes into consideration all of the issues presented above, not turning toward religion in response to fear of death or terminal illness makes sense. For most, the task may seem too monumental while dealing with the death threat at hand and in the time constraints involved.

Do those who experience either a death threat or terminal illness and have not acted according to their religion's rules have an increased fear of death over those who have acted piously? Is it possible that religion can intensify the fear of death? Does the concept of punishment and reward for life's deeds affect the intensity of fear of death? Do those who feel their deeds have been in line with their religion's rules of behavior experience a lower fear of death? Likewise, do those who know they have faltered in following their religion's rules experience a greater fear of death? Rose and O'Sullivan

(2002) address this issue by suggesting those who believe in a reward- and punishment-based religion and do not act piously will experience a greater fear of death.

Does life review have a correlation to fear of death? Thorson (1991) suggests one reason for the elderly having a reduced level of fear of death is due to a positive life review. It would seem more appropriate for the elderly to have a more substantial and positive life review than their younger counterparts. One would expect the elderly to have so many more experiences from which to evaluate and review. One would expect that the elderly have done and achieved much in their many years. A life review does not seem to be an event you plan for Sunday at noon: it would seem to be a spontaneous exercise of reflection. It would seem to make sense that younger adults do not spend much time in reflection of their lives since they are still trying to figure out what their lives are going to be. Likewise, it takes time to build a life that one can be proud of and look back and think life was an overall good experience. For the most part the young are so full of wants and needs it would seem hard for them to reflect on life with a positive attitude when so many needs and wants are unfulfilled and not yet realized.

An elderly positive life review can be as simple as reflecting on life and feeling there have been more good moments than bad. It can be as complicated as having assessed life and figured out what is really important and act accordingly. Perhaps some of the elderly have had time to right their past wrongs. Some elderly individuals may look back on their life and feel it was fairly good and therefore expect a positive experience in afterlife. Some may reflect on work, relationships, and/or personal victories and feel a sense of accomplishment. Some may look back at their children and grandchildren and feel their life had meaning. A positive life review is a very individual thing and there may be many reasons for life review lowering the fear of death in the elderly. Each aspect listed above has either an element of satisfaction with life, a sense that life had meaning, or a belief in afterlife (these three elements comprise the definition of spirituality as will be shown later).

Freud (1961) explained how religion not only keeps the masses in line but also soothes or takes the edge off fear of death:

> It can clearly be seen that the possession of these ideas [religion] protects him [man] in two directions - against the dangers of nature and

> Fate, and against the injuries that threaten him from society itself (p. 18).

When Freud is referring to the dangers of nature and Fate amongst other things, he is referring to death. McMordie (1981) seems to agree with Freud in that he hypothesized that high religious convictions foster a sense of control and predictability over death, which in turn lessens the fear of death. If Freud and McMordie are correct and religion takes the edge off the fear of death, what aspect of religion is responsible? How is religion defined?

Falkenhain and Handal (2003) explain many researchers define religion in terms of afterlife belief. The majority of religions in the United States are Christian based. The defining term, afterlife belief, works for most religions here in America, but what about the non-Christian based religions? For some non-Christian based religions, the afterlife belief criterion may not apply. McGrath (2003) defined religion in terms of being an organized system of faith and worship in order to strengthen the relationship with the divine or superior being. This definition of religion does not directly deal with an aspect of afterlife belief. Rasmussen and Johnson (1994) define spirituality as "high levels of satisfaction with life, strong feelings

that life is meaningful, belief in an afterlife, and degree of certainty about life after death not tied to a particular religious denomination" (p. 314). This definition of spirituality deals directly with an aspect of afterlife belief. Many studies do not make a differentiation between religion and spirituality. One can see there is a definite delineation between religion and spirituality. It would be helpful for studies to recognize and utilize the delineation.

The results of Rasmussen and Johnson's study showed spirituality had a significant negative correlation to death anxiety; i.e. as spirituality increased death anxiety decreased. Using Rasmussen and Johnson's definition of spirituality (throughout this project Rasmussen and Johnson's definition will be used to define spirituality) and the results from their study, it would seem logical for one to expect death anxiety to be lessened as one experiences higher levels of satisfaction with life, and/or stronger feelings that life has meaning, and/or a higher belief in afterlife.

If the inference above is true, it could lend support to Thorson's suggestion that a positive life review may be partly responsible for the elderly having a lower fear of death than their younger counterparts. A positive life

review minimally contains either a sense of satisfaction with life, and/or a sense that life has meaning, and/or a belief in afterlife. Since a positive life review of the elderly contains any one or all of these elements and since these elements comprise Rasmussen and Johnson's definition of spirituality there certainly seems to be some sort of connection. Thorson, although he did not come out and say it, found that a positive life review contains an element(s) of spirituality. Thorson's study was done three years prior to Rasmussen and Johnson's, but perhaps if he would have had their definition of spirituality while conducting his study, he would have incorporated their definition or defining elements in his study.

Thomas (1994) interviewed "spiritually mature elders" about their ideas of death. He described them as containing "a quality of warmth and what might best be termed serenity" (p. 178). One might interpret this quality of warmth or "serenity" as coming from the idea that these spiritually mature elders had come to terms with nature and death. Thomas explained the thing that most surprised him about these interviews was the positive image of death that these interviewees held. Each of the interviewees held some sort of afterlife belief and expressed no fear of dying.

Obviously, those researchers whose studies produce similar results are in agreement. While it seems that McMordie is in agreement with Freud and Thorson, Thomas, and Rasmussen and Johnson are in some sort of agreement involving spirituality, most studies recognize ambiguity on the subject of religion and fear of death. Falkenhein and Handal (2003), Kurlychuk (1976), Rasmussen et al. (1998), Rasmussen and Johnson (1994), Rose and O'Sullivan(2002), and McMordie(1981) all cite the ambiguous nature of the relationship between religion and fear of death.

Some studies support a positive, some a negative, and others a curvilinear correlation between religion and fear of death. A positive correlation between religion and fear of death means as the level of religion is increased, the level of fear of death is also increased. A negative correlation between religion and fear of death means as the level of religion is increased, the fear of death is decreased. A curvilinear correlation means those at the high and low levels of religion experience lower fear of death than those who fall somewhere in the middle of religiosity. There does not seem to be a predominant result or school of thought for the relationship between religion and fear of death. However, there does seem to be

a repetitive negative correlation between spirituality and fear of death.

Some of the ambiguity of past studies may be caused by researchers not delineating the difference between spirituality and religion. McGrath (2003) and Rasmussen and Johnson (1994) seem to be going in the right direction by attempting to define terms and thereby eliminating ambiguity. There seems to be a need for more defining terms and probing questions when dealing with the correlation between religion (spirituality) and fear of death.

Osarchuk and Tatz (1973) appear to have increased the fear of death in a sample of students by subjecting them to a death threat treatment. Rasmussen et al. (1998), tried unsuccessfully to indirectly alter fear of death by subjecting students to a relaxation and stress management treatment. An interesting future response to Osarchuk and Tatz's and Rasmussen et al. studies would be to determine if fear of death can be lowered by attempting to increase a sense of higher satisfaction with life and/or convincing the subjects that their life has more meaning than they thought prior to the study. First, one would pretest terminally ill and/or elderly subjects for level of fear of death. Second, the subjects would be subjected to

individual counseling sessions whereby an attempt is made to increase their sense that life has meaning and satisfaction with life. Finally, a posttest of fear of death would be administered. It would be expected that fear of death would be decreased from pre to post testing.

Of the 12 studies (see page 118, Categorized List of Annotated Bibliography - Religion) included in this literature review which deal with religion and the fear of death, eight used a convenience sample of students, three used an elderly sample (Falkenhein & Handal, Kurlychuk, and Thomas), and one used a terminally ill sample (McGrath).

One has to question the eight convenience samples of students. Do the eight convenience samples of students really represent the population, which the study desires to generalize? The three elderly samples and the terminally ill sample make much more sense than a convenience sample of students. The elderly and terminally ill are probably closer to death than the sample of students and may therefore present a truer representation or greater insights into the relationship between religion (spirituality) and the fear of death. For the most part, there seems to be a need for better sample selection. More studies that include the terminally ill and elderly would seem more appropriate and representative of the population,

which could give better insights to and perhaps show a truer relationship between the fear of death and religion (spirituality).

Of the 12 studies, utilized in this portion of the literature review, seven used scales and questionnaires that other researchers developed, two used interviews (Thomas 1994, and McGrath 2003) and two made their own arsenal of test questions (Osarchuk & Tatz 1973, and Thorson 1991). It seems with the ambiguous nature of the correlation between the fear of death and religion (spirituality), researchers should rely on their own questions or interviews more often to try and find a new approach to the correlation between the fear of death and religion (spirituality). It seems if one keeps asking the same questions and getting conflicting answers, it is time to change the questions. That is not to imply that the scales and questionnaires made by other researchers are deficient. Perhaps the existing questionnaires have served their purpose, and it is time to try something new and original. Or maybe some of the existing questionnaires and scales should be used in conjunction with new questions.

### *Fear of Death and Meanings of Death*

What is it that we fear about death? Abdel-Khalek (2002) extracted 18 fears of death by polling over 1,000 students. The 18 items were made into a list attached with a five-point Likert scoring system and became known as the Reasons For Death Fear Scale(RDFS). These 18 fears of death include: 1) fear of heavenly punishment, 2) worry about one's children, 3) having too many sins, 4) life teems with meaningful things, 5) leaving loved ones behind, 6) leaving behind secular pleasures, 7) fear of hell and doomsday, 8) the terribly strenuous moment when the soul leaves the body, 9) failure to perform religious duties and obligations, 10) vague and unknown issues associated with death, 11) the element of surprise in death, 12) lack of faith, 13) the grieving of loved ones, 14) torture of the grave, 15) acute pain associated with dying, 16) grieving over what one will leave behind (wealth and valuables), 17) loss of self or identity, and 18) the end of one's plans and objectives.

Most of these 18 items are understandable; a few need further thought. Leaving behind secular pleasures (#6) and grieving over what one will leave behind (wealth and valuables (#16), at first thought these two items seem to be indicating the same thing. Secular can mean non-

religious, worldly, or material. If one uses worldly as the meaning for secular, then the meaning for leaving behind secular pleasures could mean the pleasure of a sunrise, or sunset, the pleasure one derives from viewing the Grand Canyon, etc. Item number 6 does not have to mean leaving behind materialistic things. One can see, with reflection, items 6 and 16 are different.

Another item that bears further thought is number 4. What does "Life teems with meaningful things" mean? What does the phrase "meaningful things" indicate? Are these material possessions? Does Abdel-Khalek mean life has meaningful experiences? Does this statement imply that death does not have meaning, and only life can have meaning? Does this statement simply mean life has meaning and does not intend to imply in any way that death does or does not have meaning? This reason for fear of death may need to be reworded to better reflect the author's true meaning of the statement.

If item number 4, life teems with meaningful things, is viewed as simply indicating life has meaning and one takes into account the definition of spirituality, then one might expect this item's score to reflect a high level of agreement for those who have a low fear of death. Likewise, for those with a high fear of death, one would

expect this item's score to reflect a low level of agreement.

Item 12, lack of faith, and item 14, torture of the grave, bear a closer look. What does lack of faith mean? Is it lack of faith in God? Is it lack of faith in an afterlife? Is it lack of faith of a reward for just deeds? Does it mean a lack of faith in anything or everything?

What does torture of the grave mean? Does torture of the grave mean a separation from loved ones? If so, then it is redundant with item number 5. Is it a fear of bugs eating you and the body deteriorating? Does torture of the grave mean the pain and suffering that one will experience in hell? If so, then this item is redundant with item number 7. Is it a fear for the soul?

According to Abdel-Khalek (2002) overall, women rated torture of the grave highest as a fear of death. If the meaning of torture of the grave can mean so many different things, how does one interpret the fact that women rated this highest as a fear of death? Is it simply enough to know that torture of the grave was the number one rated fear of death for women? Is it better to try to attach some meaning to this particular choice of women? It seems difficult to attach meaning when there seems to be such ambiguity.

How effective would it be for a researcher to use the RDFS in a study? If five of the 18 items seem somewhat ambiguous and may need further thought, would the researcher expect the study subjects to reflect on these items and clear up any ambiguity associated with the items? Is it okay that the items are ambiguous? Are scales and questionnaires designed with a predetermined allowable amount of ambiguity? If so what is the lowest, highest and optimal? It would seem the more concrete the intended meaning of scales and questionnaires the better one could interpret the data that these scales and questionnaires produce.

This retort is not meant to be an attack on Abdel-Khalek's study (His study has many merits). Besides the obvious questioning of some of the reasons for fear of death, it is meant to instill questioning of all scales and questionnaires. It is an attempt to challenge one to look closer at the items in a scale or questionnaire and see if some sort of ambiguity exists, if there is redundancy, and do the items make sense. If ambiguity exists, can it be mentally negotiated? If redundancy exists, can it be eliminated or does it serve a purpose? Is there an opportunity to reword the item and eliminate the ambiguity? Is the item so ambiguous that it needs to be eliminated?

It would seem that knowing what fears of death one could potentially have would help one deal with these fears if they ever presented themselves. Knowing potential fears of death should give some insights into death itself. It is the intent of this portion of the literature review to reveal a sizeable example of potential fears of death. Lester and Abdel-Khalek (2003) revised the Collett-Lester Fear of Death Scale to include 32 potential fears of death items. Instead of listing all 32 items, the items which correspond to items listed in Abdel-Khalek's RDFS will be omitted. The remaining items include: the total isolation of death, shortness of life, how will it feel to be dead, never thinking or experiencing again, the intellectual degenerating of old age, the uncertainty of how bravely you will face death, your lack of control over the process of dying, dying away from loved ones, losing a loved one, seeing a dead body, regret over not being nicer to a loved one when they were alive, growing old and alone, feelings of loneliness, guilt for being relieved that the person is dead, being with someone who is dying, having the dying person want to talk about death, watching the dying person suffer in pain, seeing the physical and/or mental degeneration of the dying person, not knowing what to do about your grief at losing the dying person while you are

with him/her, and being reminded of your own mortality. From the lists above, the best one can conclude is fear of death is a very individualized concept with many fears of death being shared by individuals.

Galt and Hayslip (1998) found a reciprocal relationship between overt (conscious) death fear and covert (unconscious) death fear, i.e. as one is high or raised the other is low or lowered. Is this relationship a defense mechanism of the mind to keep one from being overloaded with fear? Does the mind determine there is sufficient fear at the overt level so there is no need for much fear at the covert level? Is there a balance that exists between covert death fear and overt death fear in a mentally healthy person?

If this balance is violated, does the person become a candidate for a clinically diagnosed mental illness? Is it possible for one to have no fear of death at both the overt and covert levels? If so, does this person exhibit a reckless lifestyle? If there is too little overt fear, does the mind then determine there should be a significant amount of covert fear and increase the covert fear? It seems a healthy level of fear has functionality to it. If one has at least some level of fear of dying, she/he probably would live with a certain amount of caution and

not live life with a sense of earthly immortality. A certain amount of fear of death could act as a motivator. It would seem one would try to get things done in a timely manner and have some sense of urgency because there is only so much time to achieve things. As undesirable as death may be, it seems to have some functionality and meaning.

When one reads a study, if the results make sense then one tends to give more credence to the study. Cicirelli's (1998) study falls into this category. The results of the study found the elderly chose extinction as a meaning of death less often than their younger counterparts. The reluctance of the elderly in choosing extinction as a primary meaning of death makes sense if one looks at the items included in this category.

According to Cicirelli (1998), extinction included five personal meanings of death items. 1) Death means pain and suffering. It seems that the elderly would score higher overall on this particular aspect of the extinction category. Surprisingly, there was not a significant difference between the young and the elderly on this aspect of the extinction category. Perhaps this is due to the elderly being more experienced in pain and pain management. Or it could simply be that the elderly felt stronger about other meanings of death. 2) Death as a means of personal

extinction. Since many studies show the elderly have a stronger belief in afterlife than their younger counterparts, the elderly scoring this aspect lower seems to make sense. 3) Death means the end of one's dreams. This makes sense since the elderly, by this stage in their life, may either have realized many of their dreams, come to terms with unrealized dreams, and possibly have changed their dreams to include some sort of reunion with dead loved ones or a union with God. 4) Death means separation from our loved ones. The elderly may look at death to mean they have an opportunity to be with their loved ones. Conversely, the young who have probably not experienced as much loss as the elderly are more likely to view death as a separation from their loved ones. 5) Death means loss. Again, the elderly may look at loss differently than their younger counterparts. They may not be as tied to material possessions or dreams as the young are. Many of the elderly's loved ones may already be dead, so loss for others may not be a factor. The disinclination of the elderly in choosing extinction as a primary meaning of death seems viable.

Cicirelli (2001) posits that those who saw death as meaning extinction also had an overall greater fear of death. Those who saw death as meaning some sort of an

afterlife also showed a lower overall fear of death. It seems that more times than not, as one looks closer or in more depth at fear of death, spirituality comes into play.

From Cicirelli's suggestion above, if one has a belief in afterlife, one will have an overall lesser fear of death than those who see death as extinction. Could one infer that as the level of belief in afterlife increases, one's level of fear of death decreases? The statement above only takes into consideration the afterlife aspect of spirituality. Could one go a step further and expect that those with the highest levels of spirituality, which include all three aspects, (belief in afterlife, high level of satisfaction with life, and a strong sense that life has meaning) experience almost no fear of death?

Hoelter (1979) defines fear of death as "an emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation or anticipation of any of the several facets related to death" (p. 996). Since anticipation involves a future event, it seems that one could eliminate a great deal of fear of death by staying in the present. Staying in the present would probably not eliminate all fear of death since not only does this definition of fear of death deal with anticipation but also contemplation.

It would seem that contemplation should fall under staying in the present. But contemplation seems to be harder to control. The mind tends to wander naturally. The minute one is told not to think about some subject, is the very moment one seems to be drawn to that subject. Staying in the present would seem easier to control than contemplation. There is always so much taking place at any given moment in time. By staying in the present, the mind could easily stay busy taking in all that there is to experience at that moment.

Perhaps the act of being tested for fear of death in some way induces fear of death. Most people do not sit around and think about their fears of death unless either they know someone who has recently died or for some reason they feel death is near, sensing their mortality. Typically, during fear of death testing, one is asked to contemplate death and in some way anticipate what it is like to die or be dead. Anticipating and contemplation are the action verbs in Hoelter's definition of fear of death.

The subject of most fear of death tests involve fears associated with death. Asking one to contemplate and anticipate the subject, death, would seem to invoke fears because of the very nature of what is being asked. The questionnaires and scales may raise issues not previously

considered. These issues can potentially become new fears of death. Is it possible that in many instances, by the questions included in the tests regarding fear of death, fear of death studies reflect elevated levels due to the testing at hand?

A possible example of testing raising fear of death scores is Knight and Elfenbein's (1993) study where the pre-study to post-study level of fear of death increased. The study was designed to ascertain how a death education course would impact the fear of death. The authors' explanation for the increased level of fear of death was twofold. First, they explained a student (enrolled in the death education class) announced she was in remission for cancer. This certainly could have affected the overall outcome of the study. This information could possibly limit the class participation in discussion on death due to an overall uneasy feeling for their cancer-survivor classmate. This sort of information could also lead the class to question their own mortality. The second possible explanation given was a student was informed her mother had just died of cancer. This information could have the same affect as the first explanation.

A third possible explanation, a view not held by Knight and Elfenbein, could be due to the barrage of

testing the students were asked to complete. During the second week of class, the students were administered four questionnaires. Eight to nine weeks later, the students were asked to complete four more questionnaires. This battery of questionnaires could have increased the students' level of fear of death by causing them to think about fears of death they may have never even considered prior to this study. If one even remotely accepts the argument that testing in and of itself can affect the outcome of an experiment or study, then such a large battery of questionnaires could increase the level of fear of death in these students.

Kastenbaum (1996) acknowledged the potential flaw of anticipatory evaluations as opposed to experiential evaluations. This can become a monumental problem when testing people for fear of death. Suppose one does not really have any fear of death but in order to fill out the questionnaire or complete the study he/she is asked to anticipate potential fears of death. Does this become representative of a true measure or sense of fear of death? Suppose one has all sorts of fear of death, but in order not to look quite so fearful the actual level of fear is suppressed.

In reality, what people think they would do in a situation is often quite different from what they actually do when the situation arises. The ideal situation would be to ask the dead what it is like to be dead and were their pre-death fears of death warranted or a waste of their emotional energy. Since one cannot readily ask the dead questions, it seems the closest one can come to this ideal situation is to examine those who have had near death experiences (NDEs).

### *Near-Death Experiences*

The term near-death experience (NDE) was coined by Dr. Raymond Moody, in his 1976 bestseller *Life After Life*, to describe the anomaly of resuscitated patients who, upon regaining consciousness, reported similar experiences of a return from death. More than 25 years later, NDEs remain a popular subject often invoking controversy, fascination, intrigue, and allure.

Why are people so fascinated and drawn to stories of NDEs? Cook, Greyson, and Stevenson (1998) posit the reason for the public's general interest in NDEs centers around the belief that NDEs occur at death or the brink of death and therefore provide a brief hint of what is to come after death. Most people want to believe there is some sort of

life after death. Whether there is life after death or not, believing there is tends to soften the idea of death. Life after death lessens the finality of death. It offers hope to an otherwise dismal ending.

People tend to find evidence or supporting data to reinforce their belief systems. NDEs tend to provide some sort of supporting evidence or a suggestion of life after death, particularly for those who need to believe in life after death. One reason for the high interest in NDEs may be due to some people needing to support belief in life after death.

Lommel et al. (2001) defined NDE as "the reported memory of all impressions during a special state of consciousness, including specific elements such as out-of-body experience, pleasant feelings, and seeing a tunnel, a light, deceased relatives or a life review" (p. 2040). Their definition of NDE includes some of the many phenomena that describe an NDE. Other phenomena common in NDEs include accelerated thought processes, hearing oneself pronounced dead, a life review, ineffability in describing the event, extreme feelings of joy, peace and love, meeting dead relatives or people, a friendly voice, a living dark or light, seeing or sensing some sort of a manifestation, a sense that life counts, otherworldly dimensions, seeing or

knowing scenes beyond one's individual frame of reference, and revelations of greater truths, etc., (Atwater, 1999, 2001, 2003; Cook, Greyson, & Stevenson, 1998; Greyson, 1983, 2000; Kelly, Greyson, & Stevenson, 2000; Lange, Greyson, & Houran, 2004: Moody, 1976; Owens, Cook, & Stevenson, 1990; Ring & Lawrence, 1993)

Even though most of the phenomena above may seem to have pleasant connotations, not all NDEs are pleasant. According to Rommer (2002), approximately 18 percent of NDErs have a "less than positive" (LTP) experience. Rommer defines an LTP NDE as "one which the experiencer interprets, in part or whole, to be frightening because it elicits feelings of terror, despair, guilt, and/or overwhelming loneliness" (p. 9). Even though the LTP NDE is not positive, Rommer cautions against calling LTP NDEs negative. She explains the LTP NDEs elicit many of the positive aftereffects experienced by positive or regular NDEs and should therefore not be referred to as negative. According to Atwater (2003), LTP NDEs can include a threatening void, a hellish purgatory, scenes of startling and unexpected indifference, and/or haunting from one's past.

Lange, Greyson, and Houran (2004) and Atwater (2003) suggest there is a hierarchy of phenomena within the NDE.

Atwater (2003) and Grayson (1997) suggest that regardless of brevity or cause of the near-death experience, the complete gamut of aftereffects ensues. Intensity alone seems to be the key factor in an NDE rather than length of scenario, content, or cause.

NDEs include not only the phenomena of the initial experience but also a host of aftereffects. Atwater (2003) explains the nature of NDEs: "The pattern of aftereffects cannot be denied; the experience, can" (p. 86). NDEs are usually subjective and therefore provide little verifiable evidence or supporting data to give them credence. Because of lack of verifiable evidence, in many cases, the experience is denied by the experiencer and/or not believed by others. The aftereffects the experiencer takes from the NDE are long-term, real and therefore cannot be denied.

The aftereffects of NDEs can include an increased concern for others, reduced level of fear of death, strengthened belief in afterlife, reduced interest in material possessions, increased self-worth, increased appreciation for human life and natural phenomenon, increased spirituality, increased intelligence, problems with relationships and integrating the NDE, etc., (Atwater, 1999, 2001, 2003; Greyson, 1992; Groth-Marnat & Summers, 1998; Kelly, 2001; Lommel et al., 2001; Rommer, 2002).

Most aftereffects take some time to be integrated by the NDEr, with the exception of belief in afterlife and reduction in fear of death. Children NDErs take longer to integrate the aftereffects than adult NDErs. The average adult NDEr usually integrates the experience in seven years, while the average child NDEr takes twice as long. (Atwater, 1999; Lommel et al., 2001)

Does the NDE socially limit the experiencer because of the ineffability of the experience? Does the experience put the NDEr at a different level of understanding and therefore limit the ability to socially interact with non-experiencers? Do the aftereffect changes take so much energy and attention that it becomes hard for the NDEr to reintegrate socially?

Quimby (1989) offers some insights into why the NDErs have difficulty integrating their experience into their lives. He suggests NDErs are propelled into an altered state of consciousness without any warning or time for preparation. NDErs experience phenomena that in some way forces them to create a new reality to deal with what they have experienced. They are ill-prepared to deal with both the near-death experience and the new reality from which they live. Most NDErs reinvent their sense of self because their belief systems are altered by their experience.

Many NDErs feel they have met with a higher being or presence. How does one react to this? Does one proceed with a sense that they were somehow special and chosen to have been graced with such a presence? One obviously cannot go on with the status quo; it seems their life is forever changed. There is a tendency for NDErs to be reluctant to share their experience with others. Greyson (1997) suggests many NDErs doubt their sanity and fear rejection or ridicule, so they are reluctant to freely share their experience with others.

Above, Quimby suggests NDErs are propelled into an altered state of consciousness; this altered state of consciousness is an important premise of the survival hypothesis. The survival hypothesis maintains that consciousness can survive and function independently of the physical body, possibly surviving death. One may, therefore, view this survival of consciousness as providing some hint of support of life after death. According to Cook, Greyson, and Stevenson (1998), there are three features of an NDE that support the survival hypothesis 1) enhanced mentations, 2) out-of-body experiences, and 3) paranormal perceptions.

Enhanced mentations of an NDE include the mind being brilliantly clearer, lucid and exceptionally enhanced, and

vivid sensory experiences. During an NDE, both thoughts and senses at their lowest point are equal to the normal conscious state but are often greatly enhanced surpassing those of their normal conscious state. During unconsciousness, mentations are expected to be non-existent or minimal. Having normal or enhanced mentations when greatly diminished or no mentations are expected may provide some evidence that consciousness may survive independent of the physical body and even after the body has died. According to Cook, Greyson, and Stevenson (1998), one could look at these enhanced mentations as support for the possibility of mentations after death. If there are mentations after death, this could be viewed as a form of life after death or more specifically the consciousness surviving independent of the body.

The second feature supporting the survival hypothesis is out-of-body experiences. OBEs involve the mind and body being separated. If the body is in one spatial plane and the mind is able to see the body from a different spatial plane the two are clearly separate. This phenomenon can lend support that the mind (consciousness) can survive independent of the body.

The third feature supporting the survival hypothesis is paranormal perceptions. These perceptions involve a

person reporting events that occurred beyond their normal scope of physical senses, seeing or knowing events that one could not observe under normal conditions even if one were conscious. Paranormal perceptions can provide supporting evidence of the survival hypothesis since these perceptions occur independently of consciousness. Paranormal perceptions tend to be objective in nature and often may be verified.

According to Kelly, Greyson and Stevenson (2000), an out-of-body experience, enhanced mentations, and paranormal perceptions are capable of occurring independent of an NDE. While enhanced mentations, out-of-body experiences, and paranormal perceptions can individually provide some questionable hint of evidence of the survival hypothesis, all three occurring within the same NDE can lend stronger support that consciousness can survive independent of the body and possibly death.

Greyson (1992) posited NDErs had a lower degree of death threat, indicating that NDEs may be instrumental in altering death beliefs. Greyson described how death threat relates to fear of death and death anxiety. He described death threat in terms of a relatively stable orientation of thought toward death, in contrast to fear of death and death anxiety, which were defined in terms of being more

conditional and emotional orientations toward death. It seems safe to infer from the descriptions above that changing one's death threat, which is static, would be harder than changing one's fear of death and death anxiety, which are dynamic, and subject to conditions and emotions.

Since Greyson suggests a link between lower death threat and a belief in afterlife, and those with a belief in afterlife have a reduced fear of death, then one might expect those with lower death threat to also have a lower fear of death. An interesting future study could be to determine if death threat and fear of death have a positive correlation. That is to say, as death threat is lowered, fear of death is also lowered and visa versa.

There seems to be some confusion as to exactly which kind and number of phenomena are necessary to constitute an NDE. Does it simply require one or two features or several from the many lists of NDE phenomena that occur in current literature? It is not enough for someone to say "I had a near-death experience" and therefore his or her experience gets counted as an NDE. At present, there does not appear to be a standard number or necessary phenomenon required to differentiate an NDE from a non-NDE.

Moody (1976) compiled a list of 15 common phenomena experienced by NDEs. Of the 15 possible phenomena, the

most Moody found one person to experience were 12; there was no indication of a minimum number necessary to qualify an experience as an NDE. Of the 150+ cases that Moody reviewed, there was no single phenomenon reported by only one person. Likewise, there was not a single phenomenon that occurred in all of the cases Moody studied.

Cook, Greyson, and Stevenson (1998) chose three categories of phenomena for NDEs. For an NDE to be included in their study, it had to contain at least one phenomenon from each of the three categories. They did not go into detail or specifically state how they initially defined the criteria constituting the initial pool of NDEs from which they selected the NDEs presented in their study. Kelly, Greyson, and Stevenson (2000) chose four categories of phenomena of NDEs. They have the same flaw as Cook, Greyson, & Stevenson of not defining the criteria constituting the initial pool of NDEs from which they selected the NDEs presented in their study. (Since Greyson was involved in both of the above studies one could be pretty sure the Greyson NDE scale was used to determine the initial pool of NDEs, but this was not specifically stated.)

Many researchers use Greyson's NDE scale, which delineates an NDE as one that scores seven out of a

possible 32 items (Greyson, 1992, 2000, 2001; Groth-Marnat & Summers, 1998; Lange Greyson & Houran, 2004). It would be helpful if future research would utilize some sort of standard to determine an NDE from a non-NDE. If Greyson's scale is the most widely accepted instrument to qualify an NDE as such and the majority of the scientific community agrees, then future NDE research should initially use this scale as the criterion for qualifying an NDE as such. This sort of objective standard delineation would seem to lend some credence to otherwise questionable personal accounts of NDEs.

If the scientific community cannot come up with a standard, how are their studies of NDEs supposed to be accepted as credible? If the scientific community cannot agree on a standard, it would be useful for each study to explain the criterion used to qualify an NDE as such. It is not enough for a study to simply state "out of 150 NDEs …" without an explanation of the criterion for noting an NDE as such.

Lommel et al. (2001) posit the terminally ill have similar experiences to NDEs called deathbed visions. Because of the connection between NDEs and deathbed visions it seems it would be very helpful for the terminally ill to study NDEs. Knowing the possible content of an NDE could

let the terminally ill know what they could potentially experience if they were to have a deathbed vision. Knowledge of NDEs may eliminate or lessen the fear of the initial onset of the deathbed vision. Foreknowledge could ease the terminally ill's fear of death by knowing the NDEr believes the NDE is a hint of what it is like to be dead. It might be helpful for the terminally ill to know that most NDErs lose almost all fear of death.

It would almost seem that an aggressive study of NDEs by the terminally ill would facilitate an almost welcoming attitude of a deathbed vision. That is not to say that one is looking forward to dying, or actively pursuing death. Looking at the phenomena associated with NDEs, and knowing a deathbed vision is similar to an NDE, it may seem desirable to experience a deathbed vision in a terminally ill state. The thought of an overwhelming feeling of peace and joy, a sense of harmony with the world, and a sense of being separated from one's body (particularly if the terminally ill person is in pain) would seem desirable.

Throughout this literature review there seem to be more questions than answers. This does not mean the researchers have not advanced their field of study. In fact, it can be viewed as just the opposite. The researchers have presented sufficient food for thought to

invoke questioning. They have instilled enough research to allow one to know enough to ask questions.

There are certainly many new avenues to explore and the need for more data to be gathered. There is a need for more standardization and less samples of convenience. The researchers in this literature review have opened up the taboo nature of death and dying and have put it out on the table for discussion. The final thought I would like to leave you with comes from Moody (1976) "I believe that any light whatever which can be shed on the nature of death is to the good" (p. 157).

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# ANNOTATED BIBLIOGRAPHY

***Abdel-Khalek, A. (2002).***

Why do we fear death? The construction and validation of the reasons for death fear scale. *Death Studies*, 26, 669-680.

This empirical study was designed to construct and validate the Reasons for Death Fear Scale (RDFS). Three hundred and seven undergraduate college students from Egypt volunteered for this study. The respondents were asked, "Many persons fear death. From your point of view, what are the different reasons for this fear?" The respondents' replies were used to construct the initial item pool. This initial pool was analyzed and modified to delete repetitive, ambiguous, or irrelevant items. The remaining items were edited for brevity and clarity. A preliminary version of the RDFS was given to four associates of the Kuwait University Psychology Department who further edited the item pool.

The modified RDFS, containing 23 items, was administered to 255 volunteer students. The 23 items were analyzed. Five items with low correlations were

eliminated. The final form of the RDFS (article appendix) consisted of 18 items.

The resulting RDFS succeeded in fulfilling the study's objective of answering, "Why do we fear death?" The RDFS was closely correlated with both the Templer Death Anxiety Scale and an additional rating scale for death anxiety. It was correlated to a lesser degree with two scales designed to measure general anxiety. The author posits this makes sense since the RDFS is more closely related to death anxiety than to general anxiety and therefore offers discriminate validity of the RDFS.

The author acknowledges the bias of using a single culture and invites similar studies with other demographics. The author hypothesized that comparing the present study's results with another culture such as a Western culture might show that the differences overshadow the similarities (The author did not explain why he expected this). Again, the author suggests further investigation is needed to support or refute his hypothesis. The author does a nice job of explaining the need and process of construction of the RDFS.

***Atwater, P. M. H. (2003).***
Our tiniest near-death experiencers: Startling evidence suggestive of a brain shift. *Journal of Religion and Psychical Research*, 26-2, 86-97.

This empirical quantitative study was designed to differentiate the experiences of adult and child near-death experiences (NDEs) and to offer support to the hypothesis that many children experience a brain shift following an NDE. From a pool of 277 children who had an NDE, 52 completed a lengthy questionnaire, intelligence quotient test, and a test for genetic markers. The author uses data from both the larger group of 277 and the smaller group of 52 throughout this study.

The author categorizes NDEs into four types: initial, unpleasant, pleasant, and transcendent. These vary in complexity with "initial" being the least complex experience and increasing in complexity to "transcendent" - the most complex NDE experience. Interestingly, the author suggests the intensity of NDE determines the impact of aftereffects, while brevity or complexity had little or no affect on aftereffects.

Of the 52 subjects who filled out questionnaires, 48 percent tested at genius level without testing positive for genetic markers signifying genius potential. From the 277 NDE group, testing those who had their NDE under the age of six resulted in 86 percent testing at the genius level. From the same 277 NDE group, testing those who had their NDE at 15 months or earlier, resulted in 96 percent testing at a genius level. I found these numbers astonishing! It was hard for me to comprehend such a high number of respondents testing at a genius level. The author posits this data as suggestive of a brain shift occurring in children who have an NDE.

The author explains that children take much more time than adults to integrate the aftereffects of their NDE. Children can take as long as 20 or more years for integration, while most adults integrate the after effects in seven years. Adults integrated themselves to fit their NDE experience. Children balance themselves between what they know and the unique strangeness of their NDE experience.

Interestingly, the author reported 21 percent of the entire group attempted suicide twelve or more years after their NDE. Not because their life was

difficult but because they wanted to return to "the other side." The author explained: the children associated not breathing with being in a heavenly environment. When they started breathing, the heavenly environment disappeared. From the children's perspective, to stop breathing would mean a return of the heavenly experience. Only three percent of the entire group experienced an unpleasant NDE. The author did not specify if any of these children were suicide attempters. Also, these suicide attempts occurred 12 or more years after the NDE, which would mean that some of the attempters would be adults. This means that the explanation that the child correlated not breathing to a heavenly experience would only qualify for some of the 21 percent of suicide attempters. The author did indicate the majority of NDEs occurred in children six years or younger but did not give raw data.

This article was full of astonishing findings. There was almost too much useful information in this article to do it justice in three short pages. The author has researched NDEs for over 25 years and has written several books on NDEs. This article is highly recommended.

***Cicirelli, V. G. (1998).***

Personal meaning of death in relation to fear of death. *Death Studies*, 22, 713-733.

This empirical quantitative study was designed to ascertain the relationship between personal meaning of death and death fears. Of the 265 college students who participated, 225 were aged 19 to 25 (younger group) and 40 were aged 26 to 55 (older group).

Participants were administered 30 statements (study - table 1) designed to measure their personal meaning(s) of death. The participants were also administered the Leming Fear of Death Scale (LFDS, a 26-item test designed to measure several types of fear of death). From these two tests, three dimensions of death meanings were evaluated: death as extinction, death as a new beginning, and death as a legacy.

Of the three dimensions of death, extinction was the only dimension for which age and gender differences were found. The younger group identified extinction as a stronger meaning of death than the older group did. Women also scored this dimension higher than their male counterparts.

Three components of fear of death were defined: intrapersonal, interpersonal, and transpersonal.

Intrapersonal includes fear of not achieving goals and fear of annihilation of the body. Interpersonal includes fear of wellbeing of loved ones and fear of loss of social identity. Transpersonal includes fear of the unknown and fear for punishment. The dimension of extinction calculated death fears for all three components.

Since extinction was the only dimension in which age and gender differences occurred, I wonder if there is some link here. Were the age and gender differences caused by the complexity of the fear of extinction? It might be useful for a study to identify other dimensions of fear that have a tertiary complexity of fear and compare it to less complicated dimensions of fear and see if there is a correlation.

***Cicirelli, V. G. (2001).***

Personal meaning of death in older adults and young adults in relation to their fears of death. *Death Studies*, 25, 663-683.

This empirical quantitative study was designed to ascertain whether personal meanings of death and fears of death held by young and old adults were related to age and gender, and whether personal meanings of death

were related to fears of death. This study can be viewed as a follow up study to Cicirelli's 1998 *Personal Meaning of Death in Relation to Fear of Death* above. Cicirelli mentioned in his previous study the need for more research on older adults' fear and meaning of death. The author follows his own suggestion with this present study.

The respondents were separated into two groups: young and older adults. The young group contained 78 respondents aged 19 to 29. The older group was comprised of 68 respondents aged 70 to 97. The Cicirelli Personal Meaning of Death Scale was administered to both groups to measure four dimensions of death meanings: 1) legacy, 2) afterlife, 3) extinction, and 4) motivator. The Multidimensional Fear of Death Scale (MFODS) was administered to both groups to ascertain the types and degree of fear. Four dimensions of fear from the MFODS were used: dying process, being destroyed, the unknown, and fear for significant others.

The results for meanings of death showed the older group scored higher on death as "afterlife" and "legacy" but lower on death as "extinction" and "motivator" than the young group. Women scored higher

on death as "extinction" than men. There were no significant differences for death as "legacy."

The results for fear of death showed the young group and women had a greater fear of the dying process than the older group and men, respectively. Young adults showed a greater fear for significant others than older adults did. Fear of the unknown was higher among young adults and men than for older adults and women.

The results for meanings of death as related to fears of death (both groups, young and old) showed that a greater fear of the dying process was related to strong views of death as "extinction." Greater fear of being destroyed was related to weaker views of death as "afterlife." Greater fear of the unknown was related to stronger views of death as "afterlife" and weaker views of death as "extinction."

***Cook, E. W., Greyson, B., & Stevenson, I. (1998).***

Do any near-death experiences provide evidence for the survival of human personality after death? Relevant features and illustrative case reports. *Journal of Scientific Exploration*, 12-3, 377-406.

This article presents seven published cases and seven cases from the authors' collection containing all three chosen features (listed below) of near-death experiences (NDEs). These cases are presented with the intent to convince researchers and NDErs of the need for better studies and reporting of NDEs with the chosen three features.

There are many features associated with NDEs; the authors chose the following features because when all three are present, they offer evidence supporting the survival hypothesis: 1) enhanced mentations, 2) out of body experience (OBE), and 3) paranormal perceptions. The survival hypothesis maintains that consciousness/personality can and does occur outside the body regardless of consciousness.

Of the 14 cases presented in this study, all but one are not verifiable and were reported or discovered by the authors many years after the NDE occurred. The verified case involved a cardiac patient who, while under anesthesia and for all appearances was unconscious, experienced himself leaving his body and watching the surgery team from above. He described in detail one of the doctors flapping his arms as if he was trying to fly. The cardiac patient's observation

of the surgeon's strange motion was verified. It seems the surgeon had the habit of folding his hands into his armpits with his elbows out prior to surgery. The other 13 cases were equally compelling but not verifiable.

The authors present a good case for timelier reporting and verification for cases containing the three chosen features of NDEs. This article presents interesting cases and peaks one's interest to find more such cases.

***Falkenhain, M., & Handal, P.J. (2003).***

Religion, death attitudes, and belief in afterlife in the elderly: Untangling the relationships. *Journal of Religion and Health*, 42-1, 67-76.

This quantitative empirical study was designed to clarify the ambiguous relationship between death anxiety and religion reported in literature. The subjects were comprised of 71 people 65 to 87 years of age, of which 24 percent were males. The respondents were recruited from religiously affiliated nursing homes and assisted living centers and a public education program for elderly adults.

The respondents were given four questionnaires: 1) Hoge's Intrinsic Religious Motivation (IRM) Scale designed to evaluate intrinsic religiousness, 2) Osarchuck and Tatz's Belief in Afterlife Scale (BAS), designed to measure nonreligious belief in afterlife, 3) Templer's Death Anxiety Scale (DAS) designed to unidimensionally measure fear of death or death anxiety, and 4) Klug's Death Acceptance Scale (KDAS) designed to evaluate death acceptance.

The results showed a high level of relatedness among measures used to test religion, belief in afterlife, death anxiety, and death acceptance. Death anxiety and belief in afterlife were not significantly correlated. The authors found a strong relationship between intrinsically religious respondents and a strong belief in afterlife. Because there was a considerable overlap in measurement of belief in afterlife and intrinsic religion, the authors performed further analysis to remove the overlap. The relationship was found to be relatively low after retesting.

The authors offer three possible explanations for the ambiguity of previous studies on the relationship between death anxiety and religion. First, some

studies do not use a death anxiety measurement with established cut-off scores to determine clinical meaningfulness. Second, the ambiguity may be due to the lack of measuring for strength in association between death anxiety and religion. Third, the measure of religion may be confused with belief in afterlife, since most Christian religions embrace belief in afterlife as a construct of their religion.

***Florian, V., & Mikulincer, M. (1997).***

Fear of personal death in adulthood: The impact of early and recent losses. *Death Studies*, 21-1, 1-24.

This quantitative empirical study of 270 volunteer students from Israel was designed to determine the effect of early and recent losses on the fear of death. The research showed interpersonal (relationship based) fear of death was associated with early loss while intrapersonal (mind and body based) and transpersonal (based on the transcendental nature of self) fears of death were related to recent loss.

Questionnaire methodology was used to determine if loss was experienced either during childhood or within the previous two years. A group of 86 students from Israel over the age of 18 were selected as having

at least one significant loss during childhood or adolescence. A control group of 86 participants were chosen that did not experience an early loss. The control group and the early loss group were then polled to see if they had suffered a recent loss (within the previous 2 years). This recent loss group was comprised of 16 subjects from the early loss group and 18 subjects from the control group.

This article left me with questions. For example, the authors included parental divorce or separation as an early loss. Since the parents were still alive, I did not feel they should be included in this sample population. Also, it would have been helpful to know the questions contained in the questionnaire.

***Galt, C. P., & Hayslip, B. (1998).***

Age differences in level of overt and covert death anxiety. *Omega*, 37-3, 187-202.

This quantitative empirical study was designed to ascertain the relationship between overt (conscious) and covert (unconscious) death anxiety and chronological age. The sample included a younger group aged 17 to 25 years and an older group aged 60

or older. There were 46 in the younger group and 40 in the older group. The participants were administered a battery of tests including: a demographic test, the Templer Death Anxiety Scale (DAS), the Collett-Lester Fear of Death Scale (FODS) and the Incomplete Sentence Bank (ISB) which measures covert death anxiety.

The older group scored higher on the DAS, while the younger group scored higher on the ISB. The authors suggest the older group's score indicates the group was more concerned with overt death anxiety. The authors also suggest the younger group's high ISB score indicates they are more threatened by their own death than the older group. The results also showed a reciprocal relationship between overt death anxiety and covert death fear. If overt death anxiety was higher, covert death fear was lower. The authors suggest this lessens denial.

This was not mentioned in the study, but it would be interesting to see if when overt death anxiety is low, is there a reciprocal relationship with covert death fear. Is covert death fear higher when overt death anxiety is lower?

This study produced a lot of other data such as the older group denied fear of painful death and the possibility of reliance on others due to disability. The younger group was less fearful of the loss of others while their older counterparts were more fearful of such loss. Interestingly, for personal mortality, both groups reported the same level of reported fear. Not surprisingly, the data indicated the older group showed significantly higher levels of covert fear for their own mortality. This study contained a great deal of findings, was very informative, and was thought provoking.

***Greyson, B. (1992).***

Reduced death threat in near-death experiencers. *Death Studies*, 16, 523-536.

This was an empirical quantitative study designed to ascertain the impact of near-death experiences (NDEs) and close encounters with death not accompanied by a near-death experience (NDE) on perceived death threat. NDEs were differentiated by a score of seven or higher on the NDE Scale, while those with a score of six and under were designated as having close encounters with death.

Respondents were recruited from advertisements in the newsletter of the International Association for Near Death Studies. Respondents were asked if they had a close encounter with death. Of the 290 chosen respondents, 135 met the NDE Scale criterion for an NDE, 43 had close encounters with death but did not qualify for an NDE, and 112 respondents reported never having experienced a close encounter with death. The respondents were given the Threat Index 30 (TI-30). The TI-30 uses 30 death-relevant constructs in which the respondents were asked to rate themselves and their own imminent death on each of the 30 constructs. Greyson defined constructs as "dimensions on which things can be judged as alike or different from each other." Placement of themselves and their imminent death on opposite poles of a construct is coded a "split": the higher the number of splits on the TI-30, the greater the perceived death threat.

Of the 30 constructs contained in the TI-30, seven were identified as being "factorially pure," meaning they correlate highly with TI-30. The seven-construct subset (TI-7) was also used because of its unambiguous measurement of death threat. A second measurement of the TI-30 and TI-7 was used, asking

respondents to rate themselves and their ideal selves for the 30 and seven constructs, respectively.

The author had two hypothesizes. First, the NDErs would show less death threat than either the close death encounter group or the group who had never come close to death on both the TI-30 and the less ambiguous TI-7. Second, the NDErs would show a greater self-actualization than the other two groups as measured by fewer splits in the TI-30 and the TI-7.

The death threat scores supported the author's first hypothesis that NDErs would score lower on the TI-30 and the TI-7, therefore experiencing less death threat. The second hypothesis could not be supported: the study did not provide evidence that NDErs were more actualized than their non-NDE counterparts.

***Greyson, B. (2000).***

Dissociation in people who have near-death experiences: Out of their bodies or out of their minds? *The Lancet*, 355, 460-463.

A quantitative empirical study designed to ascertain the frequency and level of dissociative symptoms in people who came close to death. Of the 134 respondents who came close to death, 96

individuals (experimental group) scored seven or higher on the Near-Death Experience (NDE) scale signifying their experience as an NDE. The other 38 individuals (control group) came close to death but did not have an NDE. Dissociation was defined as "the separation of thoughts, feelings, or experiences from the normal stream of consciousness and memory."

The respondents were given two questionnaires: the NDE scale and the Dissociative Experiences Scale (DES). The DES is a 28-item questionnaire used to measure the degree of dissociation. The results showed the experimental group reported significantly higher scores on the DES than the control group, but not high enough to be considered to have a dissociative disorder.

The author does a thorough job of explaining the use and rules of the measurements tools. Since the definition of dissociation means separation of thoughts, feelings, or experiences from the normal stream of consciousness and because many NDEs contain an out of body experience (OBE), the very act of being out of body suggests dissociation from the normal body, the results of this study seem apparent. Also, an NDE is often referred to as an altered state of

consciousness, which would place it under the definition of dissociation.

***Greyson, B. (2001).***

Posttraumatic stress symptoms following near-death experiences. *American Journal of Orthopsychiatry*, 71-3, 368-373.

This quantitative empirical study was designed to differentiate the magnitude of symptoms of posttraumatic stress disorder (PTSD) in near-death experiencers (NDErs) and people who have a life-threatening experience but do not have an NDE. Respondents were people who initiated contact with the author in an attempt to share their life-threatening experiences. This study included 194 respondents, 148 of which tested seven or above on the NDE scale, classifying them as an NDEr. The other 46 tested below seven on the NDE scale, classifying them as a non-NDEr.

In addition to the NDE scale, respondents were given the Impact of Event Scale (IES). The IES is a 15 item multiple-choice questionnaire designed to measure the effects of traumatic events. Seven items on the IES questionnaire test for intrusive symptoms,

including infiltration of thoughts, images, feelings, and dreams. The remaining eight items test for avoidant symptoms, including denial, psychic numbing, inhibited behavior, and counter-phobic activities (e.g., It was so horrible, I tried not to think of it).

The author expected the findings to reflect individuals with NDEs would score higher levels of intrusive and avoidant PTSD symptoms than the non-NDE group. The results supported the author's hypothesis in that the NDEr scored higher on the intrusive scale than the non-NDEr. But the NDEr scored lower than patients diagnosed with PTSD.

The second portion of the hypothesis was not supported by the study's results. NDErs' scores were comparable with non-NDErs' scores for avoidant PTSD symptoms. The author offered this explanation for the comparable avoidant scores. NDErs do not typically perceive their experience with a high degree of stress and therefore do not have the need to avoid it.

As with the previous Greyson studies I have read, Greyson does a thorough job of explaining exactly what he is doing. Greyson explains the reason for the method chosen and criteria for measurement and

classification. Greyson includes a section that describes the limitations of his study and has recommendations for future studies. Greyson presents a logical and believable study.

***Groth-Marnat, G., & Summers, R. (1998).***

Altered beliefs, attitudes, and behaviors following near-death experiences. *Journal of Humanistic Psychology*, 38-3, 110-125.

This empirical quantitative study was designed to find support that the changes in people who experienced near-death experiences (NDEs) are facilitated by the NDE itself rather than simply experiencing a life-threatening situation. The authors utilized three groups for this study: the experimental group, the control group, and the significant other group. The experimental group consisted of 53 respondents who tested positive for an NDE using the Greyson NDE scale. The control group consisted of 27 participants who had a life-threatening experience but tested negative for an NDE using the Greyson NDE scale. The significant other group consisted of 45 participants who were related to either the control group or the experimental group.

The significant other group was used to rate the changes they witnessed in the experimental and control groups and to provide validation for the self-reported changes in these groups.

The control and experimental groups were given three questionnaires: 1) the Greyson NDE scale, 2) Life Changes Questionnaire (LCQ) 42 questions designed to measure the changes in a variety of personal domains, and 3) a General Demographics Questionnaire. The significant other group was given a modified LCQ in which they were asked to rate the changes and extent of those changes in their significant other following the life-threatening instance.

The results showed the experimental group was more concerned with the welfare of others, experienced less death anxiety, had more transcendental experiences, felt increased self-worth, experienced less materialism, had a greater appreciation for nature, and felt their life-threatening incident was a more positive experience than the control group. The authors suggest the results support the causal effect of the changes as being rooted from the NDE itself and not merely from the life-threatening incident.

***Hayslip, B. Jr., Galt, C., & Pinder, M. (1993).***

Effects of death education on conscious and unconscious death anxiety. *Omega*, 28-2, 101-111.

This combination study utilized didactic and experimental forms of death education to determine their effects on altering both conscious and unconscious death anxiety. The authors posit other studies have not put enough emphasis on the effect of death education on unconscious death anxiety. By placing a greater emphasis on studying unconscious death anxiety in relationship to education, the results are expected to show an enhanced effect on death anxiety.

Three hundred and twenty-nine people volunteered for this study. The control group was comprised of 199 subjects made up of general duty nurses, undergraduates from an introductory psychology course, and community volunteers. The experimental group was comprised of nurses employed in a hospital geriatric ward, staff members of a nursing home, undergraduate students enrolled in a psychology course on aging, and undergraduate students enrolled in a psychology course on death and dying. Of these participants, 81 percent were female. The experimental group was separated

into two groups: didactic and experiential. The didactic group was comprised of the students enrolled in the courses on 1) death and dying, and 2) on aging. The experiential group consisted of individuals working at a geriatric hospital ward, and a nursing home.

All participants were rated for conscious death fear utilizing the Templer Death Anxiety Scale (DAS), and the Collett-Lester Fear of Death Scale. A 25 question Incomplete Sentence Bank (ISB) designed by Hayslip was administered to all participants to assess unconscious death anxiety. The results showed the experiential respondents' ISB scores exceeded the didactic groups ISB scores, meaning they experienced increased fear of: 1) death/dying, 2) separation/ isolation, 3) loss of control, 4) existence/stagnation 5) loss of goals, 6) injury/disease, 7) pain/suffering 8) punishment/rejection, and 9) future-time.

The subjects were comprised of 81 percent women, ranging from 70 percent to 100 percent across groups. Hayslip does not tell which group contained 100 percent women. The problem is, according to Kastenbaum (1992) in his book *The Psychology of Death*; women report a higher experience of death fear than

men. If the experiential group contained 100 percent women, then how effective is this study? The results could be skewed by the fact that the group is comprised of all women and not because of the effect of education on the unconscious.

***Hoelter, J. W. (1979).***

Multidimensional treatment of fear of death. *Journal of Consulting and Clinical Psychology*, 47-5, 996-999.

This landmark study was designed to create a multidimensional fear of death scale (MFODS) and create a reliable dimension for its measurement. The author created a Likert-type questionnaire containing several fear-of-death dimensions. The questionnaire was administered to 375 Indiana University (Bloomington) undergraduates.

The MFODS measured eight dimensions of fear of death: fear of the dying process, fear of the dead, fear of being destroyed, fear of the unknown, fear of conscious death, fear for the body after death, and fear of premature death.

This study defined each of the eight dimensions contained in the MFODS. Fear of the dying process entailed the actual act of dying. Fear of the dead

concerned humans or animals that were dead. Fear of being destroyed entailed the destruction of one's body immediately after death. Fear for significant others includes fear of the death of a significant other and the effect one's death will have on significant others. Fear of the unknown was defined as fear of the uncertainty of death and the question of existence. Fear of conscious death dealt with the fear of being conscious after death. Fear for the body after death was the concern for bodily qualities proceeding death. Fear of premature death dealt with the failure to realize aspirations and experiences before dying.

I have read many studies that use Hoelter's MFODS as a collection tool for data. It was very helpful for me to get a general understanding of the eight dimensions that the MFODS tests. I found the definitions of each dimension helpful, particularly for fear of being destroyed and fear of body after death. While these two dimensions appear to be the same, after reading the definitions, they are very distinct. The fear of being destroyed is fear for the physical body. The fear for the body after death

deals with concern for bodily characteristics - not the physical body.

***Kastenbaum, R. (1996).***

A world without death? First and second Thoughts. *Mortality*, 1-1, 111-121.

The author posits that other methods besides psychometric should be used to determine levels of death anxiety. This was an empirical study of 214 students' responses to a hypothetical situation of a world without death. The students were asked to consider the following: 1)the effects a world without death would have on society and people other than themselves, 2) how would such a world affect the way you live and experience your life, and 3) with the other two questions in mind, what is your overall attitude toward a world without death?

The results showed the initial response to a world without death as overwhelmingly positive. Responses to the second part of the hypothetical situation were predominantly negative. The overall attitude was a world without death had a higher complexity and was less desirable than first thought.

The author is good at provoking thought. For instance, he asks just enough questions about a given subject to invoke the reader to ask other questions that would logically follow. He offers several areas for future studies.

***Kelly, E. W., Greyson, B., & Stevenson, I. (2000).*** Can experiences near-death furnish evidence of life after death? *Omega*, 40-4, 513-519.

An interesting study designed to provide an account of a near-death experience (NDE). The authors posit three common features reported in many near-death experiences: 1) enhanced mentations (including clarity of thought, vision, sound and logic), 2) perception of the physical body from a different plane (usually from above looking down), and 3) extrasensory perception (the least common of the features).

The authors explain that each of these features, when taken individually, have explanations other than survival of the consciousness after death. Episodes of enhanced mentations can occur under circumstances such as manic episodes, periods of enhanced creativity, or being under the influence of certain drugs. The perception of seeing one's own body from a

different plane could simply be explained as a hallucination. The authors suggest the experience of extrasensory perception does not seem to have a normal or paranormal explanation associated with it. The authors suggest that the three features together may best be hypothesized that the consciousness can perform separately from the physical brain and body.

This argument might work if the element of extrasensory perception were not so uncommon in near-death experiences. This article was centered on an elderly lady who had an NDE 60 years prior to reporting it. It was not possible to confirm her story. The authors did cite two other cases of NDEs from other studies, but without reading the studies one would have to question their validity. While the authors did explain that NDEs only provide indirect evidence of the continuation of consciousness after death, it would lend more credence to their hypothesis by finding NDEs that were confirmable. Since this was one of the first studies I read regarding NDE, further reading on this subject is warranted to ascertain my position on this subject.

***Kelly, E. W. (2001).***

Near-death experiences with reports of meeting deceased people. *Death Studies*, 229-249.

This quantitative empirical study was designed to convince the research community to take a look at near-death experiences (NDEs) from the survival hypothesis explanation. The survival hypothesis is an attempt to explain the experiences of near-death as possible evidence that consciousness continues after death. The expectation/hallucination hypothesis is an attempt to explain the experiences of near-death as physiological/psychological mechanisms. For example, one might expect to see a bright light or other phenomenon so one hallucinates the expected bright light or other phenomenon.

The author, from the University of Virginia Health System, has a database of 553 cases of NDE, of which 274 were used in this study. The cases were examined in relationship to four common phenomena of NDEs. These four phenomena include: 1) out of body experience (OBE), 2) enhanced cognitions, 3) para-normal cognitions (experiencing verifiable events that are not accessible to one's physical senses), and 4)

seeing, hearing or sensing the presence of deceased people.

An example of a relationship the author looked at was the relationship of the deceased person that was seen, heard, or sensed by the near-death experiencer (NDEr). The relationships included parents, grandparents, siblings, strangers, pets, etc. These relationships were categorized by emotional attachment: very close, close, friendly but not close, neutral and poor. The author used these data to oppose the expectation/hallucination hypothesis by explaining that a person near death would in all probability expect to see a loved one with a very close emotional attachment instead of a stranger with a neutral emotional attachment (some of the NDErs saw strangers or people whom they were not emotionally close with).

It seems the author's intent with this argument was to say - let us look at other possibilities to explain NDEs, of which one possible hypothesis is the survival hypothesis. Throughout this study, the author does a fairly thorough job of showing how the expectation/hallucination hypothesis leaves one with many questions. The author does not posit that the

survival hypothesis is the only alternative, but is a viable hypothesis to test for in future research.

***Knight, K. M., & Elfenbein, M. H. (1993).***

Relationship of death education to the anxiety, fear and meaning associated with death. *Death Studies*, 17-5, 411-425.

This was a comprehensive empirical study with a dual objective. First, to determine the influence a college death education course incorporating both didactic and experiential approaches had on death anxiety. Second, after completion of the college course, to compare the meaning of death for subjects whose death anxiety increased with those whose death anxiety had decreased.

The subjects consisted of 103 college students taking psychology courses. Of these subjects, the test group consisted of 29 students who were taking a death and dying course. The remaining 74 subjects were enrolled in other psychology courses and constituted the control group.

The subjects were given a battery of questionnaires, including: Templer-McMordie Death Anxiety Scale (DAS), Death Anxiety Questionnaire

(DAQ), and Death Attitude Profile (DAP) at various intervals throughout the semester. During the second week of class, the subjects were given three different anxiety scale questionnaires. One week later, the subjects were given a set of questionnaires designed to assess recent experiences with death and illness. Ten to eleven weeks later, the subjects were given their final questionnaires designed to assess the original three death anxiety scales and a fourth questionnaire, which asked students to evaluate their meanings of death (Semantic Differential Scale).

Overall, the results of the study showed the test group experienced significantly higher levels of death anxiety at the end of the semester than the control group. Of those who experienced a decreased level of death anxiety, they either, or, and felt themselves to be highly religious or felt death provided a greater meaning than cessation of life. The authors assert that the significance of death may be controlled by pre-existing religious convictions.

***Kurlychek, R. T. (1976).***

Level of belief in afterlife and four categories of fear of death in a sample of 60+ year olds. *Psychological Reports,* 38, 228.

This qualitative empirical study was designed to determine the relationship between non-religious belief in afterlife and four categories of death. The four categories of death come from the Collett-Lester Fear of Death Scale and include 1) fear of death of self, 2) fear of dying of self, 3) fear of dying of others, and 4) fear of death of others.

The respondents included 40 senior citizens aged 60 to 82 years. The respondents were administered the Osarchuk and Tatz Belief in Afterlife Scale and the Collett-Lester Fear of Death Scale. The results showed no correlation between level of belief in afterlife and fear of death of self, fear of dying of self, and fear of dying of others. There was a significant positive correlation between level of belief in afterlife and fear of death of others.

The author suggests the positive correlation between belief in afterlife and fear of death of others makes sense since one cannot experience their

own death but can experience the loss of someone else. Because the sample group consisted of elderly individuals, they were more likely to experience the loss of others than a group consisting of younger adults.

The author suggests one might interpret the data to mean the more an individual fears for the loss of others, the more likely they are to experience a higher belief in afterlife. The cause and effect relation suggested here is a bit questionable. Could it be that the more one believes in afterlife the more likely there will fear for the death of others?

***Lange, R., Greyson, B., & Houran, J. (2004).*** A Rasch scaling validation of a "core" near-death experience. *British Journal of Psychology*, 95, 161-177.

This quantitative empirical study was designed to validate near-death experiences (NDEs) as a "core" experience. A "core" experience is an experience whose characteristics are hardly affected by external conditions. The authors hypothesize the NDE scale will support Moody's 1975 findings (explained below). The authors expect to find a hierarchy of phenomena

within the NDE; higher trait levels are expected to have a lower probability than lower trait levels and lower trait levels are expected to be a subset of higher trait levels.

Moody's findings not only found NDEs to be core experiences but also are defined by the following essences: 1) feelings of peace, well-being and freedom from pain, 2) the sense of an out-of-body experience, 3) levitating through darkness or a tunnel, 4) aware of intense light, 5) seeing and/or communicating with a presence, 6) having one's past flash before them, and 7) being in another world of beauty and tranquility, meeting other beings and possibly communicating with them.

Respondents were 292 volunteers, of which 203 scored a seven or above on the NDE scale (study appendix) thereby classifying them as NDErs. The remaining 89 respondents were separated into three groups: 52 non-NDErs, 19 false positives and 17 false negatives (leaving one respondent unaccounted for). A non-NDEr is someone who has had a close brush with death, but scores below seven on the NDE scale. A false positive is someone who claims to have had an NDE but scores below seven on the NDE scale. A false

negative is someone who denies having had an NDE but scores seven or above on the NDE scale.

The authors used Rasch scaling to empirically test the core property of an NDE. Rasch scaling distinguishes a variable's structure from the values it may have. Computer software was utilized to complete Rasch scaling.

The results, for the NDE group, showed the NDE scale, with its interval level measurements, fit the Rasch scaling model. The NDE group also supported the author's hypothesis of hierarchical structure within an NDE. This hierarchy showed progression in which low level traits, experiences of peace, joy, and harmony occur most often; followed by less frequent mid-level traits of religious, mystical or insightful experiences; followed by the least frequent high level traits of awareness of happenings in a different time or place. This hierarchy did not vary with respect to the NDErs' current age, gender, age at time of NDE and latency.

The results for the false negative group indicated an under reporting of the following experiences: mysticism, paranormal activity, and/or religiosity. The results for the false positive group

indicated an overstatement of these experiences. The authors were intrigued that more than 40 percent of the non-NDErs did not score a one or greater on the NDE scale. The authors suggest further study of the non-NDE group to find a scale or measurement tool for which they can successfully report their experiences.

This was a difficult study to read. The study was full of technical data. The authors were very logical and pragmatic in their presentation of their study.

***Leichtentritt, R. D., & Retting, K. D. (2000).***

The good death: Reaching an inductive understanding. *Omega*, 41-3, 221-248.

This empirical qualitative study was designed to ascertain the essences of a good death with regard to past, present and future timeframes. The timeframes were delineated as 1) months or weeks prior to physiological death, 2) physiological death, and 3) after the physiological death. Twenty-six elderly individuals from Israel, aged 60 to 86 years, were solicited for the study via advertisements and personal connections. Only four of the participants

labeled themselves as religious Jews, the remaining 22 labeled themselves as secular.

The respondents were interviewed in their homes. The interviews were conducted in Hebrew. Only selected excerpts of the interviews were translated to English for this study. Participants were asked to share their meanings of the concept of a good death, what elements a good death contains, and what delineates a good death from a bad death.

The results showed 18 essences of a good death. These 18 essences were organized into five generic essences: physiological, personal, interpersonal, social, and cultural. Three essences of good death fell into the category of physiological death: 1) sustaining self-reliance and independence, 2) avoiding physical pain and suffering, and 3) retaining mental capacity. Four essences of good death fell into the category of personal death: 1) dying a natural death versus a mechanical life or promoting death, 2) finding spiritual solace, 3) sharing or isolating others from the experience of death, and 4) integrity of self and tradition. Interpersonal death contained three essences: 1) accepting one's own death, 2) others accepting your death, and 3) having the time to

say goodbye. Social death contained four essences: 1) dying at an appropriate age, 2) completing unfinished tasks, 3) autonomy of social norms (my funeral should fit who I was as a person), and 4) consequences for deviant behavior. Cultural death contained four essences 1) gaining respect, 2) leaving offspring to continue heritage, 3) promoting a legacy, and 4) the role of religion in a Jewish state.

The author identified three sets of emotions the respondents displayed: 1) anger, fear, and anxiety, 2) sadness and grimness, and 3) confidence and security. Fifteen of the 26 participants expressed anger, fear, and anxiety when interviewed. Six participants expressed grimness and sadness during the interview. Four participants expressed confidence and security while interviewed.

The results from the study are similar to other studies with the exception of the emphasis on the Jewish religion/state. The authors were very thorough in their explanation of data analysis procedures. Their writing was clear and understandable.

***Leichtentritt, R. D., & Retting, K. D. (2001).***

The construction of the good death: A dramaturgy approach. *Journal of Aging Studies*, 15-1, 85-104.

This study used a dramaturgical approach of analysis to examine transcripts taken from 26 elders from Israel. The respondents and interviews, as well as the authors, of this study are the same as those used in *The Good Death: Reaching an Inductive Understanding* published in Omega in 2000 (above).

This was an interesting study. It was unique in that made a drama out of the combined responses of interviews. Since I had previously read the original study, I am not sure this is a better way to present the findings of the original interviews in fact, I found the original study a much more believable approach. It was expected that the authors would do more with the play. Perhaps they could have shown it to a test and control group then compare their scores on a death anxiety scale. The one thing this study contributed was more excerpts of interviews translated from Hebrew to English.

***Lester, D., & Abdel-Khalek, A. (2003).***

The Collett-Lester fear of death scale: A correction. *Death Studies*, 27-1, 81-85.

This study introduces and tests a revision to the 1990 version of the Collett-Lester Fear of Death Scale (FODS). The FODS' purpose is to measure four fears associated with death: your own death, your own dying, the death of others, and the dying of others. The FODS consisted of eight questions in four sections, for a total of 32.

The revision was based on the awareness of a deviant item in the "death of others" section. Since many researchers, using the FODS summed scores of the four sections and used it as on overall indicator of fear of death, in order to keep the other three items from carrying more weight, the deviant question had either to be replaced or removed. The authors chose to remove the deviant question. Revision 3 of the Collett-Lester FODS (study appendix) now contains seven questions in each of the four sections for a total of 28 questions.

This revision was tested quantitatively with a sample of 191 undergraduate students. The results

showed an increased reliability for the "death of others" section.

***Lommel, P. V. et al. (2001).***

Near-death experience in survivors of cardiac arrest: A prospective study in the Netherlands. *The Lancet*, 358, 2039-2045.

This qualitative empirical study was designed to ascertain a cause for Near-Death Experience (NDE) and assess factors that affect the occurrence, intensity, and content of NDEs. Respondents of this study consisted of 344 cardiac arrest patients from ten Dutch hospitals who had undergone one or more successful resuscitation(s). Of the initial 344 patients, 62 patients reported some recollection of their clinical death and NDE. The authors defined NDE as "the reported memory of all impressions during a special state of consciousness, including specific elements such as out-of-body experience, pleasant feelings, and seeing a tunnel, light, deceased relatives, or a life review. Of the 62 NDErs, 21 were categorized as having a superficial NDE, using Likert scoring of the criterion listed above. The remaining 41 were categorized as having a core NDE, again using

Likert scoring of the criterion above. None of the 62 reported having a distressing or frightening NDE.

Interviews of respondents were taped and conducted at three time intervals: a few days after the initial resuscitation then, when possible, at two and eight years later. An interesting result was reported, mortality of NDErs was significantly higher than non-NDErs, and mortality in core NDErs was even higher than superficial NDErs. The authors were amazed at the detail remembered by the NDErs of their NDE at the eighth-year interview. The frequency of NDE was significantly higher in younger people than in people over 60. The authors offer a couple of possible explanations for this finding: older people have a slighter chance for cerebral recovery following resuscitation and younger people have a better chance for survival following a cardiac arrest and can therefore share their experience. The authors expressed surprise at the profound and long-lasting effect an NDE can have on a person.

The authors posit the process of change, elements taken from the life-change inventory questionnaire, including social attitude, attitude toward death, religious attitude and attitude toward others,

following an NDE can take several years. They offer the possibility of social norms suppressing the NDEr from sharing his/her story as a possible explanation. One would have to question if social norms were more supportive of NDErs would it take several years for the changes to take place? Would the changes culminate in a more timely fashion? Is it simply a matter of delayed reporting? Do the changes take place sooner but are not reported until later?

The authors brought up an interesting point when discussing the theories of NDE. How can a person know what is going on outside their body when they are clinically dead and when the brain no longer functions? Because of this question, they offer the theory of transcendence should be included as a possible explanation for such an experience.

This study was quite extensive. I was impressed with the interviews spanning eight-year duration. The authors' definition of NDE was quite broad. It does not seem to be enough to call an NDE as such, just because someone says they had an NDE. Perhaps it would have been better to use a standard NDE scale with the criterion of a score of seven or above to designate an NDE as such.

***McGrath, P. (2003).***

Religiosity and the challenge of terminal illness. *Death Studies*, 27, 881-899.

The author states an assumption in spiritual literature is the belief that when faced with a terminal illness, individuals turn to religion for answers and comfort. This qualitative study was designed to ascertain when faced with a terminal illness, was there a propensity to turn to religion.

The respondents consisted of 14 volunteer hospice patients diagnosed with less than six months to live. They ranged in age from 47 to 97. Five respondents designated a religion; eight indicated no religion; and one declared Theosophy (Buddhist and Brahmanic theory).

The respondents were asked open-ended questions on how their illness has changed how they see the world and what is important to them. The majority of respondents did not turn to religion or conversion in reaction to their illness. Some of the respondents rejected their religion in response to their illness. Three respondents turned toward religion in response to their illness.

McGrath is well published, but this study left me frustrated. While she readily gave the raw demographics data, in the "findings" section, she used the following phrases: "for some," "for others," "a few," and "most." I found myself continually asking "how many respondents?" Only once did I find an actual number for a finding but it was not under the "findings" section. It would certainly be helpful to have the raw numbers when viewing the findings of a study. I did find the results surprising. I expected the terminally ill respondents to turn to religion in response to their illness.

***McMordie, W. R. (1981).***

Religiosity and fear of death: Strength of belief system. *Psychological Reports*, 49, 921-922.

This qualitative empirical study was designed to clarify the ambiguous findings regarding the relationship between religiosity and fear of death. The 320 respondents were comprised of 120 males and 200 female students, 17 to 44 years of age. The respondents were given a self-perceived religiosity checklist and the Templer/McMordie Death Anxiety Scale.

The author hypothesized the strength of one's belief system is an important determinant in fear of death. The results supported McMordie's hypothesis. The strength of religiosity did affect fear of death in a curvilinear fashion. Respondents with self-perceived high religiosity and those with low religiosity exhibited lower death fear than the respondents who reported a mid-level religiosity. It would have been helpful for the author to detail the questions contained in each of the two questionnaires. An explanation as to why those two questionnaires were chosen may have been helpful. The notion of a curvilinear relationship makes sense. The highly religious may believe in life after death and therefore foster a sense of control and predictability regarding death. The low or non-religious may look at death as a natural finality of life. Perhaps they live life to the fullest without any expectations following death.

***Osarchuk, M., & Tatz, S. J. (1973).***

Effect of induced fear of death on belief in afterlife. *Journal of Personality and Social Psychology*, 27-2, 256-260.

This qualitative empirical study was designed to ascertain if belief in afterlife could help the individual deal with death anxiety. Fifty opinion statements dealing with belief-in-afterlife were administered to 169 students. Twenty of the opinion statements significantly separated the upper and lower 20 percent of the respondents. These 20 opinion statements were arbitrarily divided to make two, ten question, belief-in-afterlife scales (forms A and B). The respondents were separated into three groups: the death threat group, the shock group, and the control group. Each group was given either form A or form B before treatment and the alternate form after treatment.

The treatment for the death threat group consisted of a 6-minute and 35-second presentation of slides communicating a false high probability of early death for the respondents in their age group along with slides depicting automobile accidents, murder and suicide victims. After this group completed the alternate form A or B of the belief-in-afterlife scale, they were given their actual probability of death for their age group. These participants were explained the details of this study.

The shock treatment group was administered form A or B prior to their treatment. The treatment for the shock group consisted of showing them elaborate equipment, which was supposed to shock them. The administrator explained if they felt pain when shocked they should respond they were in pain and the equipment would be immediately turned off. The administrator then told the group he/she had to go get the paddles that would be connected to the equipment to shock them. The administrator left and returned approximately every two minutes explaining he/she had still not located the paddles. This routine of leaving and coming back continued for 6 minutes and 35 seconds. The shock treatment group (which was never shocked) was administered the alternate form A or B of the belief in afterlife scale and were explained the details of this study.

The control group was administered form A or B prior to treatment. The control group was given a cup with a ball attached to a string and asked to practice putting the ball into the cup for 6 minutes and 35 seconds. The control group was then administered the alternate form A or B of the belief-in-afterlife scale and the details of this study were explained.

The results showed nine of the ten death threat group increased their belief-in-afterlife scores on the second form of the belief-in-afterlife scale as opposed to a maximum of six changing in one direction (either up or down) in any other group. The authors explain that intensifying one's fear of death increases one's belief-in-afterlife score.

It would be interesting to see if the effects of the study were long lasting. If the groups were given another round of either form A or B six months after the initial study, would their scores remain unchanged? I do not believe the effects of this study on afterlife belief were long lasting and would expect their belief-in-afterlife scores to reflect their pre-study scores.

***Owens, J. E., Cook, E. W., & Stevenson, I. (1990).*** Features of "near-death experience" in relation to whether or not patients were near death. *The Lancet*, 336-8724, 1175-1177.

This empirical quantitative study was designed to ascertain differences in near-death experiences (NDEs) of NDErs who were close to death and those who were not close to death. The testimony and medical records

from 58 patients were used to create the data for this study.

The 58 patients were separated into four categories: 1) no serious illness or injury, 2) serious illness or injury but not life threatening, 3) serious illness or injury that may have resulted in death without medical intervention, and 4) significant impairment of vital signs indicating death without medical intervention. The groupings contained 18 patients in category 1, 12 patients in category 2, 10 patients in category 3, and 18 patients in category 4. Thirty of the patients who had NDEs were not near death and 28 patients who experienced NDEs were near death.

The patients, both near death and not near death, were tested for several features of NDEs. These features included enhanced perception of light, being in a tunnel of sorts, enhanced mentations, diminished mentations, positive emotions, negative emotions, belief in having left the body and seeing it from above, seeing the past, and belief that death was imminent or had occurred. The results showed a significant difference in NDErs who were actually near death experienced enhanced perception of light nearly

2:1 over NDErs who were not near death. Of those who reported not having enhanced mentations, 81 percent were NDErs not near death. Also, 62 percent of those reporting enhanced mentations were NDErs who were actually near death.

There was a correlation with the functions of enhanced light and enhanced mentations. Eighty-six percent who experienced enhanced perception of light also experienced enhanced mentations. Seventy-five percent of those reporting no enhanced mentations also reported not experiencing enhanced perception of light.

The authors briefly mention their data showed support for the physiological and psychological interpretations of NDEs. It would have been nice to have a little more detail on these interpretations of NDEs.

***Pierson, C. M., Curtis, J. R., & Patrick, D. L. (2002).*** A good death: A qualitative study of patients with advanced AIDS. *AIDS Care*, 14-5, 587-598.

This qualitative study was designed to ascertain and describe the domains that identify a "good" death. The subjects included 35 patients with advanced AIDS.

The subjects were recruited by letters announcing the intended study sent to academicians, clinicians, community-based organizations and a pool of university-associated patients who expressed interest in being notified of studies for which they may be eligible.

The data were two-fold: 1) a set of questionnaires, whose results were published elsewhere and 2) two open-ended questions, to be used in this study. The two open-ended questions were 1) how would you describe a good death? and 2) how would you describe a bad death? The open-ended responses were audio taped and coded to describe common domains present within the responses.

Of the 15 domains identified by the authors, five of the 15 were defined by more than 50 percent of the respondents: symptom control, quality of life, people present, dying process, and location. Within these five domains variations existed. For example, the domain of symptom control was comprised of three sub-groups: absence of pain, being mentally alert, and having bodies that were intact and functioning. The authors felt the variations were important because they could point caregivers to domains of concern.

Five respondents cited acceptance of death as a domain of "good" death. Participants expressed acceptance of death in terms of being mentally prepared to die. They explained that by accepting death they thought the process of death would be a better experience. This acceptance of death will tie in closely with the self-help booklet *Dying Peaceably*.

***Quimby, S. L. (1989).***

The near-death experience as an event of consciousness. *Journal of Humanistic Psychology*, 29-1, 87-108.

This theoretical article posited near-death experiences (NDEs) as altered states of consciousness. The author explains that most of us exist in the waking conscious level. Some spiritual masters exist in raised or altered levels of consciousness. One who experiences an NDE is forced to higher/altered level(s) of consciousness that one is ill prepared for.

This sudden shift in consciousness can include heightened levels of concern for others, a peaceful calm, lack of materialism, and less death anxiety. The NDEr cannot sustain the heightened level of consciousness that a spiritual master can. The NDEr

can take away some higher-level experiences (listed above), but cannot maintain the heightened level of consciousness.

The altered states of consciousness described in this article were very interesting. I would suggest this article to anyone who is doing research on NDEs or altered states of consciousness.

***Rasmussen, C. H., & Johnson, M. E. (1994).*** Spirituality and religiosity: Relative relationships to death anxiety. *Omega*, 29-4, 313-318.

This empirical quantitative study was designed to ascertain the role of spirituality and religiosity to levels of death anxiety. This study defined terms and showed why these definitions were important. Spirituality was defined in terms of: levels of satisfaction with life, intense feelings that life is meaningful, belief in life or some existence of being after death without being tied to any specific religion. Religiosity was defined in terms of the practices and rituals associated with a particular religious denomination.

The authors explain in past studies, there were discrepancies in results when trying to determine the

link between religiosity and death anxiety. Some studies support a reduced level of death anxiety in people with strong religious backgrounds, while other studies show no relationship. The authors of this study suggest the discrepancies exist because previous studies may have been testing for spirituality when they reported testing for religiosity.

Participants included 134 females and 74 male undergraduate students. The participants were administered the Templer Death Anxiety Scale (TDAS) and the Spiritual Well-Being Scale (SWBS). The TDAS tested the extent to which students experienced death anxiety. The SWBS tested for levels of spiritual and religious well-being.

The authors hypothesized that spirituality has a greater negative correlation to death anxiety than religiosity. The results supported this hypothesis: religiosity was found to have no significant effect on death anxiety, while spirituality had a strong negative correlation on death anxiety. The results also indicated that female participants had a higher intensity of death anxiety than their male counterparts.

I found this study useful particularly for the definitions for spirituality and religiosity. Overall, this article was clearly written and easy to understand.

***Rasmussen, C. et al. (1998).***

Indirect attempt to change death attitudes: Negative findings and associated relationships. *Omega*, 37-3, 203-214.

This empirical quantitative study was designed to clarify the ambiguous findings of previous studies regarding changing death anxiety attitudes. This study included a treatment group and two control groups. The treatment group participated in a four-week relaxation and stress management course. The first control group (attention placebo group) watched a series of videos with subject matter including: death, anxiety, stress, and depression. The second control group (no-treatment group) received no treatment.

The respondents were 48 total, 17 in the treatment group, 13 in the attention placebo control group and 18 in the no-treatment control group. All respondents were given a battery of tests, pre and

post, the four-week treatment period. This battery of tests included the Death Anxiety Scale, the Death and Depression Scale, the Beck Depression Inventory, Form Y of the State Trait Anxiety Inventory and the Communication Apprehension of the Dying Scale.

The results indicated no significant change from pre- to post-testing for the treatment group in reducing death anxiety. The authors suggest this lack of pre- to post-testing change is because the participants had basically an average death and general anxiety. The authors suggest general anxiety and depression are more superficial and change more readily than death anxiety and death depression (deeper forms of anxiety and depression).

This article was fairly straightforward and understandable. The authors present a good case for the ambiguous nature of previous studies of a similar nature. One might question the choice of such an extensive battery of questionnaires. Was it to ensure this study was thorough? Did the authors want to ensure they did not omit a test that later may be deemed worthy?

***Ring, K., & Lawrence, M. (1993).***

Further evidence for veridical perception during near-death experiences. *Journal of Death Studies*, 11-4, 223-229.

The authors present three cases of verified veridical (genuine) perception occurring during near death experiences (NDEs). The purpose of this article was to motivate other researchers to document and verify similar cases in hopes of collecting and presenting enough cases so that such cases will eventually become commonplace and readily accepted.

The authors present three observations common to the three cases. First, all cases described out-of-body experiences (OBEs) in which the NDEr described knowledge of events or objects that they could not have experienced under normal circumstances. Second, the knowledge of events or objects were later verifiable. And last, the caregivers who heard the testimony of the NDEr had a profound effect on their belief in NDEs.

This study uses only three cases. This does not seem like much effort. If the only criteria one used to judge a study was amount of data, this study would be lacking. Perhaps these were the only verifiable cases of an NDE that included an out-of-body

experience and the NDEr had knowledge of events or objects outside their normal realm of perception.

***Rommer, B. R. (2002).***

The frightening near-death experience: A catalyst for positive spiritual transformation. *Journal of Religion and Psychical Research*, 25-1, 9-18.

This empirical study was designed to support the author's hypothesis that a less than positive (LTP) near-death experiencer (NDEr) is responsible for the content as well as the imagery of the NDE. The examples of LTP NDEs in this article come from the author's on going study of nearly 500 cases of NDE.

The author gives six examples of LTP NDEs and relates the individual's fear to what the LTP NDEr experienced during the LTP NDE. The author maintains that an individual can and does control the content and imagery during the LTP NDE. What the author offers for evidence or supporting material is not very convincing.

The author merely looks at the person's life and relates it to the imagery and content of the LTP NDE. For example, Anthony experiences an LTP NDE in which he is descending downward. The author explains that Anthony does not realize he could have a positive NDE,

so he has a LTP NDE. And because he equates his downward descent with hell, he experiences an LPT NDE. This article is not recommended.

***Rose, B. M., & O'Sullivan, M. J. (2002).*** Afterlife beliefs and death anxiety: An exploration of the relationship between afterlife expectations and fear of death in an undergraduate population. *Omega: Journal of Death and Dying*, 45-3, 229-243.

This quantitative empirical study had a threefold purpose: 1) determine the prevailing concepts of afterlife present within the belief systems of the participants, 2) evaluate the death anxiety levels of participants, and 3) determine whether a curvilinear relationship exists between the intensity of afterlife belief and death anxiety. The authors described curvilinear as meaning death anxiety is lowest for those with the highest positive belief in life after death and those who do not believe in afterlife.

The authors hypothesized that 1) a curvilinear relationship exists between death anxiety and the positive belief or non-belief in life after death and 2) participants with a strong negative or strong neutral afterlife belief will experience higher levels of death anxiety.

One hundred and eleven college students attending a Catholic university in California participated in this study. They were given credit in their psychology courses for their participation. Participants were administered four questionnaires: three were death anxiety scales (Templer's 1970 Death Anxiety Scale, Osarchuk and Tatz's Belief in Afterlife Scale and the Afterlife Expectation Scale), and one was demographically based.

The results indicated that of the predictor variables: religious commitment, family income, and gender, only gender showed a correlation with death anxiety (women scored higher than men did). No evidence was observed to support the anticipated curvilinear relationship between death anxiety and belief in afterlife. The authors expressed surprise in observing 1) the positive correlation between joy/reward expectation with strength of afterlife belief and 2) the positive correlation between judgment expectation and belief in afterlife. The authors suggest a greater expectation in punishment and judgment are associated with stronger afterlife belief.

One might question the authors' surprise in finding a positive correlation between judgment expectation and belief in afterlife. Is it because strong afterlife belief is not necessarily viewed as a positive or as being reward based, but can also be linked to punishment or judgment? If one behaves appropriately, judgment can be a good thing. Conversely, if one behaves inappropriately, judgment could be severe.

***Sharma, S., Mosen, R. B., & Gary, B. (1997).***

Comparison of attitudes toward death and dying among nursing majors and other college students. *Omega*, 34-3, 219-232.

The purpose of this empirical study was twofold: 1) examine the reliability estimates for Hoelter's Multidimensional Fear of Death Scale (MFODS) and 2) compare death attitudes of students with a nursing major to students from non-nursing majors. The authors hypothesized 1) death attitudes of nursing majors would be at variance from attitudes of non-nursing majors, and 2) death attitudes of nursing students would vary from freshman through senior status.

Four Hundred and five students participated in this study: 24 percent were nursing students, and 76 percent were from other majors. Participants were administered the MFODS along with 22 demographic questions. The results were consistent with the authors' hypotheses. Nursing students experienced less fear than other majors with regard to fear of death and dying, and freshmen experienced more fear than seniors. The authors assert MFODS is still a reliable and valid method of measurement.

***Thomas, L. E. (1994).***

Reflections on death by spiritually mature elders. *Omega*, 29-3, 177-185.

This qualitative study was based on interviews with elderly people from England and India considered to be spiritually mature. Spiritually mature was defined in terms of being intrinsically religious, whereby the elder was in harmony with his/her religious beliefs.

It does not appear the interviewer had a clear goal in mind when conducting the interviews. The interviews did have two findings: 1) men described death in terms of spatiality, in terms of a new domain

or entity, while women described death in terms of relationships and 2) all of the respondents described death in positive terms and did not express any fear of death.

One might construe the positive attitude toward death and lack of fear of death as having a direct correlation with the level of spirituality of the elders. I found one response particularly profound: " we grow by losing things." I have repeatedly experienced personal loss and have consequently felt growth because of the losses.

***Thorson, J. A. (1991).***

Afterlife constructs, death anxiety, and life reviewing: The importance of religion as a moderating variable. *Journal of Psychology and Theology*, 19, 278-284.

This qualitative empirical study was designed to determine the relationship between religiosity, belief in afterlife, and death anxiety. The author hypothesizes: 1) a negative correlation between belief in afterlife and death anxiety and 2) belief in afterlife would better predict the level of death anxiety than would church attendance or self-rated level of religiosity.

The respondents included 389 students who were administered a death anxiety scale and three additional questions. The three questions dealt with belief in afterlife; two involved self-rating of religiosity, and the one inquired about church attendance. The results showed church attendance and self-rated religiosity had the lowest correlation with death anxiety for women and was not significant for men. Those who were less certain about afterlife showed the highest death anxiety.

The results of the study confirmed the author's hypotheses. The author did recognize self-reported information did not necessarily constitute a true scale and was not tested. The fact that a convenience sample was used was also noted.

***Vig, E. K., Davenport, N. A., & Pearlman, R. A. (2002).*** Good deaths, bad deaths, and preferences for the end of life: A qualitative study of geriatric outpatients. *Journal of American Geriatrics Society*, 50-9, 1541-1548.

This qualitative empirical study was designed to determine what constitutes a good or bad death and end of life decisions. Respondents were recruited from

geriatrics clinics at two university-affiliated medical centers. Physicians were asked to identify heart disease or cancer patients who were expected to live for at least six months, were physically able to come to clinic appointments, and were mentally intact. Sixteen patients aged 60 to 84 years participated, 14 were male and two were female. Respondents were asked open- and close-ended questions and their responses were audio taped and transcribed. The open-ended questions included inquiries such as 1) "What would you consider a good death? A bad death? Why?" 2) "When thinking ahead to your own dying, under what circumstances would you prefer to die at home or in the hospital? Why?" The close-ended questions were answered using a five-point Likert scale. Respondents were asked about such issues as preferred place of death, presence of religious/spiritual counselors, presence of family members, and ability to do things for oneself, etc.

Results from the questioning revealed several common themes for good death: dying at home, in one's sleep, without pain, quickly, without suffering, and without knowledge of impending death.

Interestingly, the most common themes were cited by less than half the respondents. The reasoning for the common themes was diversified. For example, the reasons given by respondents for dying in their sleep included: for some, the lack of pain or suffering, for others, it meant no knowledge of impending death and for one respondent it meant not using up the savings so there would be something left for their spouse.

The authors stated many clinical implications for this study; these were not included in this annotation since my research did not involve clinical implications. I would infer, from this study, that death universally surpasses time and space and is a very individualized process that is influenced by cultural norms and religious/spiritual beliefs.

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***Religion***

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# APPENDIX

DYING PEACEABLY: A BOOKLET OF HELP FOR THE TERMINALLY ILL

## *The Booklet*

This section will describe the post-graduation *Dying Peaceably* booklet, i.e. its final form for the terminally ill. The booklet will contain a table of contents with section headings. (This will facilitate easier referencing for individual obstacles.) The main section headings will include four headings: 1) introduction, 2) help for the terminally ill, 3) transcendence, and 4) additional readings.

Under the main heading *help for the terminally ill*, subheadings will include: realization, shock and numbness, constricted awareness, denial, anger, "why me?", bargaining, depression, vulnerability, and fear. The subheading *fear* will have the following subheadings: loneliness, loss of family and friends, loss of physical body, loss of self-control, pain, loss of identity, and sorrow. Transcendence will have the same subheadings as below (relaxation, withdrawal, intensity, and knowing).

## *Introduction*

Chances are if you are reading this booklet, either you or someone you know has a terminal illness. This booklet is written for the terminally ill. It would certainly be a help to family members or friends. (If the

reader is a family member or friend, the goal is to try to understand what the terminally ill are going through; to gain some insights as to what they may experience. By knowing what your friend or loved one is experiencing, this should invoke you to understanding and compassion for their situation.) This booklet is not designed to be all-encompassing in describing every possible obstacle a person might experience.

Dying is a very personal experience, but many of the obstacles described in this booklet are shared by the terminally ill. This booklet will describe some common obstacles experienced during a terminal illness and offer suggestions on how to get past them. The goal is to overcome the distractions of this world and any fears you may have so you can gain acceptance of your situation and die peaceably. This booklet is in no way suggesting you should or will experience any or all of the obstacles described. The main purpose of this booklet is to get you past fear and other distractions so they can accept your situation and die peaceably.

I lost my father to melanoma cancer. I wished I had a booklet like this to share with him, something to give him an idea of what he might go through and suggestions on getting through it. Since his death, I have done much

reading, some technical, and some personal experiences, on many obstacles that the terminally ill have experienced. This booklet is a condensed version of what I believe to be the most common obstacles experienced by the terminally ill. Many obstacles discussed in this booklet came from Elizabeth Kűbler-Ross[1]. There is a section at the end of this booklet of additional readings that can point you in the right direction if you are looking for more technical and in-depth material.

## *Help for the Terminally Ill*

You know you have been sick and getting worse, but you are not aware of the magnitude of your situation. Realization of the magnitude of your situation usually occurs when you are told by a health care professional your illness is terminal. Many personal accounts describe how instantaneous the transition is from being healthy or mildly sick to the realization of being terminal. It is like being on a mountaintop, taking in all of the beauty of that nature is offering, then suddenly plummeting off the

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[1] The obstacles from Kűbler-Ross include denial, anger, bargaining, depression, and acceptance. Kűbler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

side of the mountain into a black abyss. In an instant of realization, your life is forever changed: you have gone from being sick to having a terminal illness.

This information is usually followed by the thought "there must be a mistake; I will get a second opinion." This is very logical thinking, even professionals make mistakes. When the second diagnosis concurs with the initial diagnosis, there can be little doubt of being cognizant of your situation at this point.

The magnitude of a terminal illness is just too much to bear. You are in shock and numb. Shock and numbness[2] are defense mechanisms of the mind. They protect the mind by overlooking or lessening the degree of threat. Deepak Chopra, the author of many spiritual growth books, described shock and numbness as constricted awareness.

Constricted awareness is like being on an interstate with road construction. Prior to construction, driving is unrestricted without any feeling of congestion, just as life was before diagnosis. A mile or so before the site of road construction, a "merge left" sign appears. Traffic is still moving along pretty good; some cars start to merge

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[2] The obstacles of shock and numbness (constricted awareness) come from D. Chopra. Chopra, D. (2001). The deeper wound. New York: Harmony Books.

into the left lane. This corresponds to first being sick; you are still functioning very well, but you are sick just the same. Your routine is still normal but things are starting to happen. You realize your sickness is starting to affect your overall health and functioning. Another mile down the road, barrier horses appear in the right lane forcing cars into the left lane.

At this point, you have an appointment to see your doctor; you know you must get some medical help for your illness. Suddenly traffic is at a bottleneck and appears to be at a standstill. You have been diagnosed with a terminal illness. Constricted awareness has occurred, you are in shock and numb. Constricted awareness can be thought of as a traffic jam of your emotions and attention. Concern, kindness, and understanding are lessened; laughter is elusive; and the world around you is treated with indifference.

Your mind is so focused on dealing with your illness that it has no time or energy to deal with your normal routine, let alone the outside world. You seem to be experiencing an internal focus. The rest of the world is functioning like there are no problems or concerns, but for you all you can think about is your illness. You may become very angry about your situation.

Constricted awareness may, but does not have to, lead to denial. We are taught all our lives to ignore the possibility of death. We tend to deny things we don't understand. We understand so little about death that it is easier to deny death than to deal with it; at least not to deal with it until we are forced to. Frequently, the truth is just too much to handle; you can't believe this is happening. There must be a mistake; your illness can't be terminal. You think with time, you know you will get better and everything will be okay.

Denial is the mind's defense mechanism to protect itself from overload when receiving news that is simply too overwhelming. Denial allows the mind, the much-needed time, to recuperate and come to terms with the devastating news of a terminal illness. Denial is a very common experience.

Very few people experience the element of denial for extended periods of time. During the early stages of a terminal illness, many may fade in and out of denial. But as they grow sicker, and their bodies start to fail, there is little doubt of their situation and their minds have had time to adjust to their dying. They quickly move past the obstacle of denial.

Anger is a distraction. It keeps you from losing control and at times may make you feel like you are maintaining a sense of control. You stay angry enough to vent the frustrations of your situation. You maintain just enough anger to vent but not so much anger that you blow up and lose control. You cannot be in control of your health, but you are in control of your anger.

Whom do you get angry at? For some it is easy to be angry with God. Some may even deny the very existence of God for allowing them to have this terminal illness. For many it is a little hard to get mad at God. God is the Creator and the presence that they desire to be in when they die and leave this world.

Displacement is easy. You get mad at whomever or whatever comes your way. You lash out at anything or anyone who crosses your path. Anger takes a lot of energy. Energy you could better spend dealing with the reality of your illness. Anger can eat at your soul and wear you down. In your anger the question "why me?[3]" may occur.

Many personal accounts of terminal illness reflect on the element of "why me?" "Why me?" seems like a logical

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[3] The obstacle of "why me?" comes from Robert Horn III. Horn III, R. (1997). How will they know if I'm dead? Transcending disability and terminal illness. Delray Beach, FL: Lucie Press.

question. Where is the justice in choosing you for the terminal illness? This is a rhetorical question that is asked in hopes that magically the injustice will be recognized, and you will soon become healthy again. Most people who ask "why me?" soon realize how self-defeating the question is.

Arthur Ashe, a professional tennis player who was diagnosed with AIDS, explained he never questioned "why me?" when winning a tennis tournament. So when he was diagnosed with AIDS he did not ask "why me?" then either. There is a lot of mental energy wasted on this question. The bottom line is bad things happen to good people. Many people who experience the element of "why me?" try bargaining as a solution to their illness.

Bargaining is a futile attempt to postpone the inevitable: death. You may think, "If I get better, then I will be more loving, forgiving, and be an overall better person." This almost implies that God is punishing you for bad behavior, or past sins, or even for your inability to forgive yourself for a wrong past. A terminal illness is not a punishment. It simply happens.

Another similar bargain is "If I take my medicine and do everything the doctor tells me to do, then I will get better." Taking your medicine and following doctors orders

may help ease the pain and slow the progression of your illness. It is probably not going to miraculously cure you. Bargaining is eventually recognized as being futile. Depression is another element that is equally futile, but often experienced by the terminally ill.

Depression can feel like an overall lack of anything enjoyable. It is often a feeling of apathy and total lack of energy. Depression often stems from a feeling of great loss. For the terminally ill the feeling of loss may involve the loss of the healthy body, with all of the freedom that it provided. It may be for the loss of employment, as the body fails they can no longer work. It may be for the loss of the future, all of the things that were planned and will never come to fruition. It may be the loss of friends and loved ones that will soon be gone. Or it may be for the loss of life itself.

Depression has feelings of helpless and hopelessness. Helplessness is feeling the situation is so bad there is nothing you can do to make your situation or life any better. Hopelessness is feeling the situation is so bad there is nothing anyone else can do to make your situation or life any better. There are feelings of intense vulnerability. You are at the mercy of your illness. You feel utterly vulnerable.

In a personal account of vulnerability, a man's body deteriorated to the point of having his eyes the only outwardly working part of his body. At first, he felt both helpless and hopeless. Then after realizing how much energy he was wasting on ruminating over his situation, he expressed great relief when the doctor told him his body had deteriorated to its final level. He could get no worse. He felt relief at not having to incessantly worry or fear for which body part would fail next. He learned to work within the frame of body he had left. His mind was still clear and he could communicate with others by blinking. Granted, it must have taken great resolve to get to the point of feeling relief at no longer being vulnerable, but it is important to move on and try to see the good in any given situation or at least work within the framework of what you can do.

Vulnerability can be viewed as a fear: the fear of being susceptible or exposed to physical or emotional damage. Fear involves the uncertain outcome of future events. An overall suggestion for overcoming fear is to stay in the present. Many terminally ill people have found it useful to stop thinking in terms of "never" and "forever"; these are just too mentally, psychologically, and spiritually painful. Try to stay in the present. The

Fear of loneliness, becoming deserted, or rejected are real and have been experienced by many people. Talk to the person or people who you fear may reject or desert you. Ask him/her as the condition progresses will he/she be there for you. Does he/she intend to see your illness through to the end? During the times you are alone, use the time wisely, this time gives you a chance to rest, plan your estate, etc. Try not to think of being alone as a curse or rejection, but as an opportunity for rest, etc.

Fear of loss of family and friends not only involves the actual loss of that person when death occurs, but also fear for emotions you are feeling toward them. Talk with friends or loved ones about your fears and emotions. These emotions may include love, remorse, hate, regret, etc. talk about it and explain you are feeling. Be open and honest. Ask them to share their emotions and fears with you. Discussing fears and emotions not only "clears the air" but also eliminates these fears from further troubling you.

Fear of loss of physical body involves fear for the deterioration of the body. Find out exactly what you are to expect in terms of your body. What if anything will fail, as well as, what will work? The key issue here is to understand that loss of body function(s) or ability is nothing to be ashamed of. Try to develop an indifference

to what others think of you and your body. Be realistic and do not only think in terms of what cannot be done but also in terms of what can be done. It will be difficult, but try to work with what you have and not dwell on what you do not have.

Another suggestion, in dealing with a failing body, is to think in terms of self-worth instead of self-esteem. Think in terms of who you are. Try to avoid thinking in terms of what you can do. It is mentally healthier and less self-defeating to think in terms of who you are than what you can do.

Fear of loss of self-control can fall under the heading of panic and anxiety. Panic is the loss of coherence, logic, and/or reality that occur when the mind cannot find some sense of control. Panic is the mind racing to find some sort of control. This can be very frightening, but does not last long. Because the mind races so fast that it doesn't take very long to find something it can control and therefore end the panic.

Anxiety occurs when the threat which caused the panic has lost its immediate edge but cannot be forgotten. Anxiety can take the form of night sweats, sleeplessness, ruminating over the consequences of loss of control, etc. There are several ways in which you can exert control and

thereby lessen the fear associated with loss of control. Make out a will. Discuss burial preferences and if necessary get suggestions. Tell family members any decisions regarding family or property that you have made. Decide how you will live your life through your illness until death occurs. Dying is very individualized; make personal choices of attitude and style. Decide how you would like to handle your situation; control what you can.

Fear of pain is very common. Most physical pain can be managed through pain-reducing medications. If pain does not seem manageable with current medication talk to your healthcare provider and ask for an alternative medicine. Try not to think of what future pain will feel like, but deal with the pain at hand.

Fear of loss of identity involves the fear that people will treat you differently than they did prior to your illness. Your life has obviously changed but perhaps you would like to be treated the same way you were before your illness. Set the tone for how others should communicate with you.

Typically, friends and family members are afraid of being too abrupt, prying, or forward, etc. They may tend to skate around a subject or feelings because they don't want to offend or upset you. They may treat you

differently because they are unsure of what is acceptable behavior. Until you set up the parameters for communication, communication may be awkward, uncomfortable, or forced.

Talk with friends or loved ones about how you want to be treated and what you are willing to discuss. Set the tone for emotions and communication. If you want them to treat you like your pre-terminal self, then tell them. If not, explain to them how you would like to be treated; tell them what is or is not acceptable.

Fear of sorrow sounds absurd! Aren't you supposed to be sad; you are dying! This fear is not fear of being sad but rather fear for the appropriateness of the grief or reasons for sorrow. It is more of a fear that you will be told the very things you are grieving and sad for are silly. If you are experiencing fear of sorrow, seek the opinion from the person that matters. Talk with him/her about your grief or sorrow. Explain the reasons for your sorrow. Find out what sorrow(s) he/she is experiencing. It may be the same sorrow(s) you are concerned with. Ultimately, grief and sorrow are yours and you are entitled to feel what you feel.

Staying in the present helps eliminate many fears. Only by overcoming your fear can you gain acceptance of

your situation. Acceptance of death cannot occur if you are experiencing fear. You need to be at peace for acceptance of death to occur. Acceptance is a peaceful resignation that death is near and you are ready. It is a letting go of all that is worldly; an acceptance of whatever is yet to come.

### *Transcendence*

Transcendence[4] has several qualities that may transpire after acceptance and when death is very near. These qualities are not sequential or experienced by everyone. Someone may experience all, one, none, or any number of these qualities of transcendence. Since these qualities of transcendence are not the destination this booklet intended to take you, but rather a hope or hint of what can follow after you overcome your fears and gain acceptance of death, their descriptions will be very brief.

### *Relaxation*

The quality of relaxation occurs when it is too much work to keep fighting: the battle for life is just too difficult. Death is perceived as an opportunity for peace.

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[4] The elements of transcendence come from Kathleen Singh. Singh, K. D. (1998). *The grace in dying: How we are transformed spiritually as we die*. San Francisco: Harper Collins.

The person has become relaxed enough to give up the struggle. There is a sense of the end of the great effort and struggle required to stay alive, a letting go and giving into death. It is a transition from being sick to dying.

### *Withdrawal*

The quality of withdrawal occurs when things of this world are no longer a concern; they are a distraction. The person may no longer speak. What she/he is experiencing is ineffable. She/he simply can't explain the experience because words fail to describe the situation properly. The person has lost herself (himself) to the outside world, in order to facilitate a deeper level of consciousness. At this point, the terminally ill need to conserve their energy and focus on the transition that she/he is about to face. She/he can no longer be bothered with the plethora of distractions from this world. She/he has turned within in preparation for departure from this realm.

### *Intensity*

Intensity is an increase in the energy of the dying person. Since the person is no longer focusing on the world around her (him), there is more energy for what is to

come. This energy seems to be gathering in preparation for the energy required to exit this world and enter the next realm. This quality of intensity is the dying person's life force radiating from him/her in preparation for his/her departure.

***Knowing***

The quality of knowing is two-fold. First, knowing involves knowing when death will occur. Understanding that in order to go to the next destination, the present existence must be finalized: death must come. The second part of knowing involves knowing death is not the enemy or a tragedy, but rather a divine grace or experience of perfection. Many terminally ill people will tell their loved ones "it's okay." At this point they understand and know death is okay and desired.

This reading should have left you with a sense that your situation is not unique; you are not alone. It should have given you some advice and helped you on your journey. If this reading leaves you needing further help, and you have access to the internet, Hospice Foundation of America has a website that may be of help, http://www.hospicefoundation.org/. This website explains what hospice does, the history of hospice, how to contact a

local hospice, how to get help for grief, end of life planning, a monthly newsletter, a recommended reading list, etc. If you do not have access to the internet, your local hospital, clergy, or behavioral healthcare center can either help you or make recommendations for where to find help.

## *Additional Readings*

Here are a few of the books that I have read that really touched me and I found particularly helpful.


Bauby, J. (1997). *The diving bell and the butterfly*. New York: Alfred Knoff Publishing.

Brookes, T. (1997). *Signs of life: A memoir of dying and discovery*. New York: Time Books.

Callanan, M., & Kelley, P. (1992). Final gifts. New York: Bantam Books.

Chopra, D. (2001). *The deeper wound*. New York: Harmony Books.

Horn III, R. (1997). *How will they know if I'm dead? Transcending disability and terminal illness*. Delray Beach, FL: Lucie Press.

Kűbler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Singh, K. D. (1998). *The grace in dying: How we are transformed spiritually as we die*. San Francisco: Harper Collins.

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**EDUCATION**

Indiana University, South Bend, Indiana May 2005

Master of Liberal Studies

Purdue University, Westville, Indiana May 2002

Bachelor of Science in Technology

Organizational Leadership and Supervision

Valparaiso Technical Institute Jan. 1987

Associate Electronic Engineering Technology

**Employment**

Technical Support Coordinator April 97 to May 1999
LaPorte Hospital, LaPorte, IN 46350

- Coordinate the technical support workflow for a staff of 16.
- Coordinate work schedules, ensuring proper coverage for departmental needs.
- System Administrator for Helpdesk Expert Automation Tool (HEAT).
- Responsible for resolving issues on various systems, hardware and applications over the phone or via PC-Duo when appropriate.
- Assign service requests to the technical personnel while balancing the priorities of the requests with the workload and projects of the Information Services employees.
- Follow up with customer, analyze the potential impact of all actions upon "Complete Care" and respond accordingly.
- Recommend and create Quality Insurance documentation as required for JACHO certification.
- Troubleshoot and repair PCs and peripheral hardware.
- Software Applications supported include but not limited to: MS Word, MS Access, MS PowerPoint, MS Outlook, MS Excel, MS Publisher, MS Windows 95, MS Windows NT, MS Explorer, Netscape Navigator, Heat, PC-Duo and Crystal Report Writer.